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Pepperdine University
Graduate School of Education and Psychology

ADDICTION RECOVERY: AN EXPLORATION OF THERAPEUTIC COMMUNITY
IMPACT IN BRAZIL

A dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Education in Organizational Leadership

by

Lyndsay Michelle Phillips

May, 2019

Lani Fraizer, Ed.D. – Dissertation Chairperson

This dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

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DEDICATION

For the men and women struggling with addiction in Brazil and around the world. For Alexandre, Tailor, Darlan, and Josimar. I learn so much from you, and you inspire me to understand more about addiction recovery and how to love people throughout their recovery journey. I pray that you continue to persevere, to stay in community, and to remain in the One who meets all of our needs.

Para aos homens e mulheres que lutam contra o vício no Brasil e no mundo. Para Alexandre, Tailor, Darlan e Josimar. Eu aprendo muito de vocês, e vocês me inspiram a entender mais sobre a recuperação de vícios e como amar as pessoas ao longo de sua jornada de recuperação. Eu oro para que vocês continuem perseverando, permaneçam em comunidade e permaneçam Naquele que satisfaz todas as nossas necessidades.

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ABSTRACT

As the number of substance abusers continues to rise in Brazil, it is increasingly critical to thoroughly assess the change efforts being made in response to the national issue. Therapeutic communities are one of the leading solutions to the addiction crisis. There are a vast number of such organizations, yet relapse rates remain high, and the number of substance abusers consistently increases. Individuals seeking long-term sobriety and a sense-of-meaning in life may not be able to depend entirely on the current efforts offered for addiction recovery. This phenomenological qualitative study employed semi-structured interviews to examine the strategies and measures for success that therapeutic community service providers utilize. Challenges service providers experience in their work guiding individuals to a greater quality of life was also investigated. Twenty-five key findings revealed insights about therapeutic community operations, residents seeking sobriety, and service providers leading these organizations. Implications for positive social change in addiction recovery were determined.

Keywords: addiction recovery, quality life, reintegration, therapeutic community

Chapter 1: Introduction

“I’ve been in and out of recovery facilities 7 or 8 times, I don’t remember how many... it’s my second time here though” (L. Phillips, personal communication, May 4, 2018). With a 7th grade education, this young Brazilian man, now 27, first went to an addiction recovery facility at age 15. When asked, his drug of choice is “all of the above.” What is preventing this man from living a sober life, positively contributing to society? Will this be his last time at a recovery facility?

In general, drug use significantly impacts a person’s quality of life, particularly one’s emotional, physical, and spiritual health (Narvaez et al., 2015). Furthermore, Laudet, Becker, and White (2009) identify life satisfaction as a predictor of remission status. Overall life satisfaction is significantly associated with drug abstinence and may be used to predict sustained remission for up to 2 years (Laudet et al., 2009). Life satisfaction is one concept associated with a satisfying sense of meaning-of-life, a purpose-in-life (Young-Hall, 2000). Other concepts include fulfillment, psychological well-being, and happiness (Young-Hall, 2000). When an individual discovers meaning in their life, they are not only able to be happy but are capable of coping with the suffering they will experience in this life (Frankl, 1992).

Factors attributing to a person’s transition to a satisfying sense of meaning-of-life are (a) a person accepting the addiction they struggle with, (b) pursuit of a higher level of education in order to know one’s self and the world better, and (c) an increase of spirituality (Young-Hall, 2000). According to Young-Hall (2000), treatment does not necessarily lead to recovery, yet 12-step programs, such as Alcoholics Anonymous (AA), lead individuals to a satisfying sense of meaning-in-life. AA is a spiritually based

12-step program catering specifically to individuals with alcohol addiction. Other programs exist utilizing the same 12-step self-supported group-based framework, yet with a focus on the corresponding addictive substance (Young-Hall, 2000).

According to the second Brazilian National Alcohol and Drugs Survey conducted in 2012, 11.2% of adolescents and 15.5% of adults used an illicit substance in the 12 months leading up to the data collection (II Levantamento Nacional de Álcool e Drogas [LENAD], 2012). Between 2006 and 2012 the percentage of the adult population who are regularly consuming alcohol and habitually drinking at least five doses each occasion increased from 29% to 39% (LENAD, 2012). Furthermore, a general profile for a substance abuser in Brazil is a young male, with a low education level, and without employment (Moreira, Bessa Fernandes, Mendes Ribeiro, & de Lamare Franco Neto, 2015). For men and women seeking treatment from their addictions, the substances the individuals most often have an addiction to are alcohol and cocaine.

With the high prevalence of substance abuse, individuals in Brazil searching to overcome their addictions have a range of options available to support their sobriety journey, from out-patient public health care to in-patient therapeutic communities that offer immersive experiences to group meetings such as AA. However, many organizations responding to Brazil's severe substance abuse issues generally lack a variety of resources and are often ineffective in helping individuals maintain sobriety long-term (Ribeiro et al., 2013; Rigacci Abdalla et al., 2014).

Organizations and their leadership must be equipped to prepare their residents for sober-living and the challenges their residents will face during resocialization in the post-recovery period (Phillips & Fraizer, 2018). Therapeutic community service

providers are typically former substance abusers themselves who do not have professional credentials nor formal training (De Leon, 1995; Ribeiro et al., 2013). Therapeutic community federations such as the Federação Brasileira de Comunidades Terapêuticas (FEBRACT) regularly offer training for professionals, monitors, and coordinators of therapeutic communities, however, the majority of therapeutic communities in Brazil are not affiliated with a federation (Ribeiro et al., 2013). Background information on Brazil's substance abuse recovery history may provide valid reasoning for organizational leaders' hesitation to join such federations.

Background

Substance use is a growing concern in both developed and developing countries, impacting the economy itself, public policies, families, and communities, and contributing to a wide range of health problems (Pereira et al., 2017). The United States, a developed country (followed by Mexico, a developing country), is the central location for cocaine trafficked into North America, with the developing country of Brazil as the primary location in South America (International Monetary Fund, 2017; United Nations Office of Drugs and Crime [UNODC], 2017). Despite being in recovery from a 2015 and 2016 recession, Brazil ranks as the eighth-largest economy worldwide (Central Intelligence Agency [CIA], 2018). As the fifth most populous country, Brazil ranks as one of the top two consumers of crack cocaine in the world, in addition to its growing problem with alcohol abuse (CIA, 2018; UNODC, 2016).

Over 2% of Brazil's population consumes crack-cocaine, with cocaine addiction identified among 41.4% of those users (Rigacci Abdalla et al., 2014). Moreover, on average, Brazilians first drink alcohol at the age of 12.5 years (Pechansky, von Diemen,

de Micheli, & Bitarello do Amaral, 2017). Although less prevalent than alcohol and cocaine abuse, over 1.5 million of the more than 3.5 million people regularly using cannabis are cannabis-dependent (Ribeiro et al., 2013). Furthermore, Brazil ranks sixth among the countries with the highest number of seized ecstasy-related manufacturing facilities (UNODC, 2017).

Recovery options trace back to efforts made in the Psychiatric Reform Movement in the 1980s. Although substance abuse was a prominent issue, critical figures that commendably influenced policy with the Psychiatric Reform Movement began influencing health reform for substance abusers as well (Ribeiro et al., 2013). Concerns policy influencers had included matters about establishing detoxification facilities, or partnerships between therapeutic communities and the public health system that could threaten civil rights just as asylums had prior to the Anti-Asylum Movement (Felicissimo, 2008; Ribeiro et al., 2013; Tavares Cavalcanti, 2008).

Poorly managed asylums for people with mental health disorders and some hospital services were available, but in the 1990s the Brazilian government responded to the rise in substance abuse by developing treatment centers and programs (Paulin & Turato, 2004; Ribeiro et al., 2013). Brazil, in addition to ten other Latin American countries, signed the Caracas Declaration in 1990 to integrate mental health care away “from hospital-based care to community-based care” (Caldas de Almeida & Horvitz-Lennon, 2010, p.218). In response to the declaration, all asylums were closed replacing them with a community-based support network in 2001 (Ribeiro et al., 2013). However, fears emerged regarding organizations requiring drug testing, utilizing abstinence-based programs, such as AA, and with detoxification centers themselves in how they are

unrealistic and pose a threat to individual rights. The Psychiatric Reform is simultaneous to the country's re-democratization and goes "hand-in-hand in the search for more humane psychiatric care, focused on improving quality of life by expanding affective and social networks" (Tavares Cavalcanti, 2008, p.1963).

In 1994, the Brazilian Ministry of Health implemented harm reduction strategies in response to the widespread of HIV/AIDS and hepatitis among users who injected drugs (Felicissimo, 2008). However, treatment engagement and retention after harm reduction strategies were introduced continued to be a challenge (Pinsky, Bernal, Vuolo, & Neighbors, 2018). Where harm reduction strategies are focused on acute health conditions, the Chronic Care Model, introduced in the mid-1990's, seeks to address chronic and complex conditions of substance abuse. In 1996, the Brazilian government put into effect a National Anti-Drug Action Program that "covers areas of supply reduction, demand reduction, control measures, institutional framework, budget, and an evaluation system" (Multilateral Evaluation Mechanism [MEM], 2000, p.1). However, despite the growing number of strategies initiated, in the early 2000s, detoxification centers were nonexistent, and halfway houses and other recovery organizations were experiments, yet to evolve (Phillips & Fraizer, 2018; Pinsky et al., 2018; Ribeiro et al., 2013).

Noteworthy legislation began to be implemented in the early 2000s to combat the drug issues intentionally. For example, the Ministry of Health started to direct mental health care to Psychosocial Care Centers (CAPS). Following the implementation of CAPS, in 2004, the Psychosocial Care Center for Alcohol and Drugs (CAPS-AD) was created as a branch of CAPS to specifically cater to those with alcohol and other drug

abuse problems through a network of community services (Pereira, Vargas, & de Oliveira, 2012; Tavares Cavalcanti, 2008).

In 2004, the Ministry of Health, in support of harm reduction strategies, approved a policy for an Integrated Attention to the Consumer of Alcohol and Other Drugs (Atenção Integral ao Uso de Álcool e Outras Drogas) (de Oliveira Manguiera, Guimarães, de Oliveira Manguiera, Carvalho Fernandes, & de Oliveira Lopes, 2015; Felicissimo, 2008). The Integrated Attention to the Consumer of Alcohol and Other Drugs policy addresses the seriousness of the drug problem by reinforcing that abstinence cannot be the only goal of harm reduction, and that recognition of a person's individual needs must be considered as well (de Oliveira Manguiera et al., 2015; Ministério da Saúde, 2003). Although significant progress was made by the Ministry of Health, public policies have regressed since 2011 (Pereira et al., 2017). For example, the Psychosocial Attention Network terminated its investment of a service of CAPS that “allows the resocialization of users in integral care and returned to the financing of hospitalizations” (Pereira et al., 2017, p. 8). Terminating support for resocialization is one distinct way a lack of attention to public policy is affecting individuals seeking to maintain sobriety and find an improved sense of meaning-of-life. Furthermore, addiction recovery options lack integration and collaboration among the various modalities, leaving Brazil with a system with significant room for improvement (Pinsky et al., 2018; Tavares Cavalcanti, 2008).

Harm reduction strategies as a practice of the national psychosocial care network are intended to reduce the harm connected to the use of drugs but it does not require drug abstinence (Teixeira, Ramôa, Engstrom, & Ribeiro, 2017). In contrast to the harm

reduction model is the disease model that is used by therapeutic communities, for drug-dependent individuals. As of 2011, there were 277 CAPS-ADs compared to the 1,179 therapeutic communities. Therapeutic communities have been in existence for more than 30 years and are a common method to address substance abuse in Brazil (Melo & Corradi-Webster, 2016). Designed to transform the lives of individuals struggling with substance abuse, therapeutic communities are one of the most common methods for treatment available (Gómez-Restrepo et al., 2017). However, it was not until 2010 that the government published the Integrated Plan to Combat Crack, a public drug policy that recognized therapeutic communities as a valid treatment option (Fossi & Guareschi, 2015).

Therapeutic communities are essentially participative facilities that operate in a group setting on a long-term basis to help substance abusers in their journey to sobriety (National Institute on Drug Abuse, 2015). The residents of controlled or semi-controlled therapeutic communities, meaning the type of therapeutic environment, remain residents for the determined amount of time arranged by the organization's leadership (Fracasso, 2017; Melo & Corradi-Webster, 2016). However, typically after three to nine months of treatment, the individuals that populate therapeutic communities, return to the same or similar environment where they last had access to their drug or drink of choice, unfortunately, often re-inserting themselves into the cycle of addiction (Fracasso, 2017; Kadam, Sinha, Matcheswalla, Nimkar, & De Sousa, 2017). The Institute of Applied Economic Research (IPEA) (2017) in Brazil reported a total of 83,530 vacancies in therapeutic communities, 67,480 for males, 3,659 for females, and 12,391 for both males and females. Therapeutic communities are intended to be an effective system for

addiction recovery, but it is up to the individual completing the program to seek and participate in aftercare maintenance, a critical component to reducing the potential for relapse (Duffy & Baldwin, 2013).

Furthermore, few academic studies review the contributions and limitations of therapeutic communities which would improve the care quality provided (Scaduto, Barbieri, & dos Santos, 2014). Therapeutic communities are a long-term residential treatment approach for substance abusers, influenced by the Oxford Group, a Christian-based movement that directly influenced the principles of AA, and Synanon and Daytop Village, therapeutic community pioneers (Fracasso, 2017). For the past decade, therapeutic communities have been “regulated by Brazilian health agencies whose regulatory framework was the publication of minimum operating standards for this treatment environment” (Fracasso, 2017, p.121). Although therapeutic communities are included by the National Drug Police of the National Secretariat on Drugs as a substance abuse treatment option, a lack of knowledge remains regarding the therapeutic community model in Brazil (Fracasso, 2017). The lack of knowledge is in large part due to the inability for organizations’ operations to meet minimum standards and lack of adequate financial and training resources (Fracasso, 2017). Therapeutic communities have gained the most traction among types of recovery facilities but are often siloed, lack the support of well-structured organizations, and frequently experience critical legal regulations (Phillips & Fraizer, 2018; Ribeiro et al., 2013). One study shows only 50% of former addicts hired to work at a therapeutic community are asked about professional or educational qualifications before onboarding, perhaps a response to the lack of professionals seeking employment in this sector (Gómez-Restrepo et al., 2017).

Additional knowledge on the growing number of therapeutic communities and how they are performing, and their quality would benefit the people being served and the government (Gómez-Restrepo et al., 2017).

Statement of the Problem

An increase of awareness on how therapeutic communities are modeled in Brazil and how they should be implemented to operate in a manner that fully meets the needs of a recovering addict is needed. Service providers, those working in the day-to-day efforts of therapeutic communities, must understand the current treatment processes and situation well in order to effectively implement improvements in their organizations (Wiener et al., 2018). By understanding how service providers work and assessing their methods and results, this study aims to provide recommendations on how to innovatively create a more comprehensive system to help individuals to integrate effectively into society post-treatment. Without this knowledge, leaders of therapeutic communities may be susceptible to maintain the status quo rather than improve their efforts and become more effective. Further understanding is needed concerning how to generate systemic change in the manner in which therapeutic communities equip substance abusers with life skills to re-enter society during their post-recovery journey. Therefore, this study seeks to understand the practices of therapeutic community service providers, how their strategies are operationalized to support the person in recovery, and how to increase support for service providers in their professional growth and development.

Purpose Statement

Thus, the purpose of this study is to understand and determine the strategies and practices of therapeutic community service providers in their respective organizations, the challenges they face, best practices used to measure success of their efforts, and their recommendations they have for therapeutic community leaders. By understanding the experiences of therapeutic community service providers, more can be understood about best practices in the operations of participative rehabilitation facilities. Findings can be valuable to assist current and aspiring leaders with strategies and information that will support their success in equipping recovering addicts in the resocialization process and improving addiction recovery processes.

Research Questions

The following four research questions (RQ) guide this study:

RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?

RQ2: What challenges are faced by therapeutic community service providers in their respective organizations?

RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?

RQ4: What recommendations do therapeutic community service providers have for aspiring leaders of therapeutic communities?

Significance of the Study

The findings of this study are significant for several different populations and areas of study, as outlined below.

- *Significance for men and women in recovery.* Men and women who seek addiction recovery depend on the recovery system to provide the support and help they need to obtain sobriety and be prepared to live a quality life (Phillips & Fraizer, 2018). This study has the potential to bring awareness to recovery facilities on how to improve their systems. If systems efficiently improve, a decrease in relapse rates among men and women in recovery and increase in sense of meaning-in-life are anticipated. Increased awareness of effective strategies in therapeutic communities is significant for the individuals in recovery and also Brazil as a nation.
- *Significance for Brazil and beyond.* This study may provide significant ways for therapeutic communities and other addiction recovery efforts to develop into more effective organizations which would move Brazil and other countries towards systemic change. Gómez-Restrepo et al. (2018) published a recent study descriptively comparing therapeutic communities in five Latin countries: Brazil, Argentina, Mexico, Peru, and Colombia. Although differences were found among the criteria analyzed, significant commonalities emerged more frequently, showing that therapeutic communities beyond Brazil could also benefit from this study. Furthermore, rehabilitation facilities are individually impacting society. However, collective impact among organizations and individuals is proven to work more successfully to solve large social problems such as the eradication of substance abuse (Hanleybrown, Kania, & Kramer, 2012).
- *Significance for rehabilitation facility service providers.* The service providers of rehabilitation facilities are a significant part of solving social problems related to

addiction recovery; they operate in the day-to-day. The findings of the phenomenon are intended to provide specific ways for service providers to improve rehabilitation facility treatment strategies (Gómez-Restrepo, 2018). Understanding how therapeutic community service providers implement the transition of their residents effectively will help leaders learn how to equip residents better, strategize their organizations, and observe areas where improvement is needed internally or externally.

- *Significance for rehabilitation facility leadership.* Rehabilitation facility leaders are capable of influencing the systemic changes needed to improve and strengthen addiction recovery (Phillips & Fraizer, 2018). System thinking leaders have the opportunity to impact systemic change in their organizations, identify and advocate for areas lacking, or gaps, in the addiction recovery system, and influence government policy.
- *Significance for government policy.* Public policies on drugs and regarding rehabilitation facilities have significantly evolved since the early 2000s. However, there has not been significant movement since 2011 (Pereira et al., 2017). The main two recovery options – psychosocial care centers and therapeutic communities – have considerable differences yet both typically align with the anti-prohibition approach (Teixeira et al., 2017). This research contributes to increasing the awareness and insights into the capabilities of therapeutic communities for the general public and policymakers and assist policy influencers by providing new information to guide their efforts.

Limitations and Assumptions of the Study

A limitation of this study is that although there are several therapeutic community federations and affiliates, the sample is limited to therapeutic community service providers affiliated with FEBRACT and the Secretaria de Desenvolvimento Social, Trabalho, Justiça e Direitos Humanos (SDSTJDH) in Brazil, and therefore not representative of all therapeutic communities. Another limitation of this study is that of potential inconsistency or contradiction in perspective or approach on how treatment solutions are promoted (Teixeira et al., 2017). It is assumed that the sample of participants have accurate recollections of their memories and can articulate them effectively (Fraizer, 2009).

Definition of Terms

This section defines how the following key terms are utilized in this study:

- *Addiction*. A chronic condition of drug dependency that places significant burdens on individuals, families, and communities (Khoo, Gibson, Prasad & McNally, 2017).
- *CAPS*. The Psychosocial Care Centers (Centro de Atenção Psicossocial, CAPS) are a strategic part of the Network of Psychosocial Attention, consisting of multi-professional teams that work on the interdisciplinary perspective and carry out, as a priority, care for individuals with mental illness or distress, including those with needs deriving from the use of alcohol and other drugs, whether in crisis situations or in the processes of psychosocial rehabilitation and are substitutive to the asylum model (Ministério da Saúde, 2018c).

- *CAPS-AD*. The Psychosocial Care Centers for Alcohol and Drugs (Centro de Atenção Psicossocial Álcool e Drogas, CAPS-AD) encompass two of the specific CAPS services that pertain specifically to substance users and the only public health services specialized in attending alcohol and drug dependent people. (Antunes da Costa, Basile Colugnati, & Mota Ronzani, 2015; Ministério da Saúde, 2018c).
- *Harm Reduction Strategies*. Strategies implemented to decrease health and social harm toward an individual abusing alcohol and/or drugs and the community (Felicissimo, 2008).
- *Leadership*. A process involving influence in a group setting with individuals working towards a common goal or purpose (Northouse, 2013).
- *RAPS*. The Network of Psychosocial Attention (Rede de Atenção Psicossocial, RAPS) is Brazil's federal health program that provides a variety of integrated support, through its six components, for the wellbeing of those with mental health issues (Antunes da Costa et al., 2015; Garcia, Santana, Pimentel, & Tykanori Kinoshita, 2017; Ministério da Saúde, 2018b).
- *Recovery*. An individual change process from substance use to sobriety which results in improved health, wellness, and ability to reach full potential of life (SAMHSA, 2012).
- *Relapse*. Recurrence of use of any substance use, drugs or alcohol, or process addiction behaviors following a period of abstinence within remission or recovery (Addiction, 2018).

- *República*. A housing service for former substance abusers reestablishing social bonds and building independence for up to 180 days, with a possible 90 days extension, and up to 15 residents per house (Secretaria de Desenvolvimento Social, 2017).
- *Substance Abuse*. Act of harmfully or hazardously using psychoactive substances, illicit drugs and alcohol (World Health Organization [WHO], 2018).
- *Therapeutic Communities*. Long-term (typically 3 to 9 months), group-based residential treatment facilities for people with substance use disorders (Fracasso, 2017; National Institute on Drug Abuse, 2015).
- *Therapeutic Community Service Provider*. An individual employed by a therapeutic community to provide aid according to the respective organization's method (Gómez-Restrepo et al., 2018).

Chapter 1 Summary

Chapter 1 introduced the issue of substance abuse experienced throughout Brazil and how it affects the individual addict, the family, and the community. A brief overview provided information on what is currently being done to confront the *war on drugs* through various models of recovery programs, predominately CAPS-AD and therapeutic communities. From which, therapeutic communities emerged as the focal point of this study.

This chapter introduces four research questions that will serve as a guide in conducting this study. Moreover, Chapter 1 provides definitions of key terminology and highlights the significance of this study. In the following chapter, Chapter 2, a review of relevant literature from researchers' and scholars' studies on addiction and recovery in

Brazil is provided. Chapter 2 will present more information for one to better comprehend the scope of the study.

Chapter 2: Literature Review

This chapter provides a literature review of the components pertinent to understanding the role therapeutic communities play in addiction recovery in Brazil. To begin, an overview of the relationship between meaning-of-life and substance abuse is provided. Following, an overview of the Brazilian population, narrowing the scope to the two specific states of São Paulo and Rio Grande do Sul, and the reality of substance use and abuse today is assessed. Furthermore, the political system is explored and readily available options for individuals seeking treatment, with an emphasis on therapeutic communities, conclude this chapter.

Meaning-of-life

Meaning-of-life and quality of life are concepts often addressed in the literature regarding substance abuse and addiction recovery. Damásio, Melo and Silva (2013), provide additional support to affirm Frankl's (1992) chief assumptions, demonstrating meaning-of-life as a valuable predictor of psychological well-being and quality of life. Quality of life, described as, "individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns" (WHO, 2002, p.2), can be evaluated utilizing instruments such as the World Health Organization Quality of Life assessment or the Short Form 36 (SF-36) (Narvaez et al., 2015). These assessments cover domains such as general health, physical health, mental health, social functioning, level of independence, environment, spirituality/personal beliefs, and vitality (Narvaez et al., 2015; WHO, 2002).

A lack of meaning-of-life is associated with increased levels of depression, suicidal thoughts, and drug addiction (Damásio, Melo, & Silva, 2013; Edwards & Holden, 2001; Henrion, 2002; Mascaro & Rosen, 2006). Frankl (1992) refers to findings obtained from von Forstmeyer and Krippner that respectively show 90 percent of alcoholics suffer from “an abysmal feeling of meaninglessness” (p.116) and 100 percent of drug addicts believe their situation seems meaningless. However, emerging evidence demonstrates that not only is there a relationship between quality of life satisfaction and substance abuse, but that quality of life is also capable of predicting continued abstinence (Laudet et al., 2009). Therefore, a goal of rehabilitation facilities should not be to promote abstinence as an end in itself but to provide residents “the necessary resources and strategies to achieve enhanced quality of life and improved functioning and to assume social responsibility” (Laudet & White, 2010, p.57) throughout treatment and post-recovery, more pertinent to this study, specifically treatment and post-recovery in Brazil.

Brazil in Context

In South America, the Federative Republic of Brazil is the largest country in size and population, it is relative to the size of the United States and borders ten countries: Argentina, Bolivia, Colombia, French Guiana, Guyana, Peru, Paraguay, Suriname, Uruguay, and Venezuela. Brazil has a predominantly tropical climate but a moderate climate in the south. The country has 26 states and the majority of Brazilians live in proximity to the vast coastline, anchored by São Paulo, Rio de Janeiro, and Brasília, two state capitals and the country’s capital. In regard to population, Brazil is the 5th largest country in the world with 207,353,391 inhabitants as of July 2017 (CIA, 2018).

Brazil's official language is Portuguese. However, several other languages aside from Spanish, on the border areas and in academic settings, are spoken: English, German, Italian, and Japanese (CIA, 2018). The majority of the country, roughly 65%, identify as Roman Catholic and about 22% Protestant (CIA, 2018). Over half of the population is considered to be part of the middle class, but inequalities remain elevated in the North and Mid-West areas pertaining to women, black and mixed races, and the indigenous population. The gap in opportunities creates social exclusion and directly contributes to the high crime rate, which can be quite violent in areas infamously known as *favelas* or slums (CIA, 2018).

The average age of Brazilians is 32 years with a population growth rate of 0.73% (CIA, 2018). Life expectancy, as of 2017, is 70.5 years for males and 77.7 years for females (CIA, 2018). Additionally, health expenses in 2014 comprised of 8.3% of the gross domestic product (GDP) with 1.85 physicians per 1,000 people (CIA, 2018). Brazil ranks the 11th country with HIV/AIDS prevalence which is 0.6% of the adult population and an estimated 830,000 people in 2016 (CIA, 2018).

Symbolic of the rise of the emerging markets that powered through financial trouble in the late 20th century, in 2014 Brazil hosted the FIFA World Cup and in 2016 Summer Olympic Games, a first for South America (CIA, 2018). However, since roughly 2013, the financial situation has declined, resulting in a shrinking economy, increase in unemployment, and rising inflation (CIA, 2018). A wide variety of construction projects throughout Brazil, intended to be finished in time for the 2014 World Cup, continue to be works in progress.

Once a military dictatorship, Brazil transitioned to democracy in 1985 and continues to operate as a federal presidential republic government. The constitution was last ratified on October 5, 1988, having been amended several times since and with the last amendment made in 2016. In May 2016, a political scandal occurred involving the former President Dilma Rousseff that resulted in her impeachment. Continuing the political scandal theme, in April 2018, former President Luiz Inácio Lula da Silva (2003-2011), better known as Lula, began a prison sentencing for corruption and money laundering that may endure for 12 years. Lula intended to run for the 2018 Presidential election but was disqualified due to his imprisonment (Lopes, 2018). Michel Temer, Rousseff's Vice President, served as President through the end of her second term, that ended January 1, 2019. The Vice President seat remained vacant from the time Temer took over the Presidency. However, after the new year, all positions were replaced when the new President, Jair Bolsonaro, took office.

In 2006, Brazil began informally coordinating with Russia, India, and China and they devised a group called BRIC. However, at the third summit meeting, South Africa became a new member of the group which was then renamed, BRICS (Ministério das Relações Exteriores, 2018). BRICS focuses on two main areas: coordination in international meetings and organizations; and the construction of a multisector cooperation agenda amongst its member countries with primary attention given to economic and financial governance, in addition to political governance (Ministério das Relações Exteriores, 2018).

Economically, Brazil is the 8th largest economy in the world but continues to recover from the 2015 and 2016 recession, noted as the worst recession in its history

(CIA, 2018). The country's GDP at purchasing power parity (PPP), in 2017, was estimated to be \$3.219 trillion dollars with the primary consumers being household consumption at 63.5% and government consumption at 19.9% (CIA, 2018). Leading agriculture and industrial products are heavily exported. Unfortunately, although the large range of products produced provide a significant amount of jobs, for example, coffee, soybeans, lumber, and steel, the unemployment rate as of 2017 is 13.1% (CIA, 2018). The unemployment rate is 1.8% higher than the previous year and approximately 4% of the entire population is considered as below the "extreme" poverty line (CIA, 2018).

One of the main transnational issues in Brazil is in relation to illicit drugs. According to the Central Intelligence Agency's research, Brazil is the 2nd largest consumer of cocaine in the world, following the United States (CIA, 2018). There is also illicit producers of cannabis and trace amounts of coca cultivation in the Amazonian area which is used for domestic consumption (CIA, 2018). Additionally, there has been a significant rise in violence that is drug-related and involving weapon smuggling (CIA, 2018).

As of 2016, 10% of murders worldwide occur in Brazil (Globo, 2016). Although progress is being made economically, public health initiatives to decrease this destruction are not a priority (Rigacci Abdalla et al., 2014). The murder victims are often marginalized, young black men, living in poor urban areas, and are target recruits for drug trafficking gangs (Miraglia, 2016). Open air drug scenes, such as the infamous Cracolândia in São Paulo, explored further, later on, is associated with high levels of crime and violence. Unfortunately, although São Paulo's police are commended for

solving one of the highest number of murders nationwide, they only solve 50 percent of cases that come through (Miraglia, 2016). As of 2016, 11 percent of males and 6 percent of women were incarcerated for homicide (Ministério da Justiça e Segurança Pública, 2017). Strategically implemented and carefully managed public policies are needed to increase control of the repercussions of illegal substance use (Rigacci Abdalla et al., 2014). The following will provide emphasis on Brazil's states of São Paulo and Rio Grande do Sul, the geographic regions of focus for this study.

São Paulo. São Paulo is the most developed and diverse state in Brazil, located in the southeast region (University of Campinas, 2014). Responsible for 33.9% of Brazil's total GDP, São Paulo alone is wealthier than the countries of Argentina, Uruguay, Paraguay, and Bolivia combined (Tavares, 2016). In 2017, imported goods exceeded US\$55 billion and exported goods over US\$58 billion (Fundação Sistema Estadual de Análise de Dados [SEADE], 2018a). As of July 2018, the population of the state of São Paulo is approximately 43.9 million with the metropolitan area of São Paulo city with 20.8 million inhabitants (SEADE, 2018b; SEADE, 2018c). The city of São Paulo, the state's capital and most populous city in Brazil, ranks as the 5th largest megacity in the world (United Nations, 2016). Three states due south of São Paulo's coastline is Rio Grande do Sul.

Rio Grande do Sul. Rio Grande do Sul is the southernmost and 5th largest state of Brazil and has a steady increase in annual expenses, totaling R\$53 billion, approximately US\$15.7 billion, in 2017 (Governo do Estado do Rio Grande do Sul [Governo RS], 2017; Governo RS, 2018). The state is populated by 11.3 million people, the capital's metropolitan area, called Delta do Jacuí, has 2.56 million inhabitants and

the state's capital, which is central to Delta do Jacuí, Porto Alegre, has 1.48 million inhabitants (Fundação de Economia e Estatística [FEE], 2016a; FEE, 2016b; Governo RS, 2017). The state government transparently focuses on three main objectives: modernizing the state, promoting growth, and serving people (Governo RS, n.d.).

Rio Grande do Sul is home to mountain ranges, canyons, and waterfalls, and one of the greatest hydrographic networks in Brazil which creates vast reservoirs of groundwater, including the Guarani Aquifer, one of the largest underground water reservoirs in the world (Governo RS, 2017). Porto Alegre is surrounded by five rivers that converge to form the Lagoa dos Patos (Lagoon of the Ducks), a giant body of freshwater known for being navigable by ships of all sizes for the highly valued port. Additionally, the diverse economy of the state has a long export tradition, based on agriculture, cattle raising, and industry (Governo RS, 2017). Understanding the general environment of Brazil offers a setting for the following which provides details on licit and illicit drug-related issues present in Brazil.

Current Drug Situation in Brazil

Male young adults with low levels of education and unemployed or without regular work predominantly characterize the profile of a substance user in Brazil (Moreira et al., 2015). Substance use severely impacts quality of life, affecting a person's general health and their surroundings - family, peers, and community (Naravaez et al., 2015; Santos Cruz & Felicissimo, 2017). Obtaining a paying job and working more than 10 hours per week is one of the many factors found to be associated with the onset of drug use by teenagers in Brazil (Poletto, Lessa Horta, Andina Teixeira, Lemes Grapiglia, & Dido Balbinot, 2015). A study of 1,961 students, ages 14 to 17, was

conducted in two cities near Porto Alegre, to look at the relationship between the insertion in labor market and substance use among adolescents, including alcohol, tobacco, cannabis, and cocaine (Poletto et al., 2015). Results indicate a significant association between insertion in the labor market and substance use; but the association increases with increasing age and in accordance with gender and patterns of care at home (Poletto et al., 2015).

When assessing the substance use environment, observing all forms of substance use from tobacco to crack cocaine to alcohol provides a comprehensive overview. Fortunately, there is little prevalence of heroin or methamphetamines in Brazil, with alcohol and cocaine being the primary drugs of choice. Case studies, factors associated with onset substance use, and data available regarding substance use in Brazil should be reviewed to assist in improving substance use recovery and treatment. The following provides a high-level overview of tobacco, cannabis, amphetamines, hallucinogens, alcohol, cocaine and crack, substance use as it relates to sexual behavior, and the relationship between substances use and mental health and behavioral issues. Statistics associated with each drug of choice (DOC) and specific studies from the literature are provided to enhance the reader's understanding of the current substance use situation throughout Brazil. The first substance reviewed is that of tobacco.

Tobacco. There are few countries in the world to have achieved documented decreases in tobacco use as a result of strong tobacco control policies, including Brazil (WHO, 2015). According to a 2013 report by the World Health Organization (2015), 20.3% of men and 12.1% of women are smokers. The significant decrease, 46%

reduction between 1989 and 2010, in smokers has been attributed to the tax and price increases implemented by policy (WHO, 2015). In 2008, the country began mandating licensure for manufacturers and a tracking system for the products (WHO, 2015). A further improved system was implemented in 2011 that tracks domestic production and exportation of cigarettes by way of special decoding equipment (WHO, 2015). The improvements and successes of the tobacco reduction experience can provide an example for other substances, such as alcohol, and the development and implementation of public policies (da Costa e Silva, Pantani, Andreis, Sparks, & Pinsky, 2013). Although strict policies are in place for tobacco, it remains a legal substance unlike cannabis.

Cannabis. The National Health Surveillance Agency (ANVISA) approved the registration of Mevatyl®, Brazil's first drug registered to contain cannabis, however, recreational use of cannabis and its cultivation remain illegal (ASCOM/ANVISA, 2017). Furthermore, where Paraguay borders Brazil is where the majority of cannabis is grown in Paraguay, one of the primary sources of cannabis in the Americas (U.S. Dept. of State, 2016). Additionally, since the legalization of cannabis in 2013 in Uruguay, there has been a concern of trafficked cannabis across the border into Brazil and Argentina (Walsh & Ramsey, 2016). One question remains, how has the legalization of cannabis in Uruguay affected the trafficking of cannabis from Uruguay into Brazil? Although the prevalence of cannabis use is lower in Brazil compared to many other countries, the characteristics of those who use it are similar (Jungerman et al., 2010).

From a cross-sectional national survey among 3006 individuals between the ages of 14 and 65, 2.1% use cannabis in a 12-month timeframe (Jungerman et al.,

2010; Madruga et al., 2012). The profile of the substance users were predominantly males with a higher education level but unemployed and living in the south and southeast regions of Brazil (Jungerman et al., 2010). Moreover, participants of a study on characteristics of cannabis users who are seeking substance use treatment in São Paulo had an average age of 32.3 years and an average onset use of cannabis by the age of 16.5 years, which developed into a daily use by 21 years (Jungerman & Laranjeira, 2008). Study participants, on average, had 15.6 years of formal education and only 61.6% reported having a place of employment (Jungerman & Laranjeira, 2008). Characteristics of cannabis were consistent with studies done elsewhere but reported slightly fewer symptoms of dependence (Jungerman & Laranjeira, 2008). The study concluded that cannabis-only users should be assessed independently in substance abuse programs due to the nature of the specific attention and treatment required (Jungerman & Laranjeira, 2008). In addition to growing concern over cannabis abuse, Brazil experiences challenges with misuse of amphetamines.

Amphetamines. Individuals in Brazil are the lead users of anorectic drugs, primarily fenproporex, diethylpropion, and sibutramine (de Cássia Mariotti et al., 2013; Nappo, Tabach, Noto, Galduróz, & Carlini, 2002). The two primary users are women looking for weight loss support and professional drivers wanting assistance to stay awake and on schedule (de Cássia Mariotti et al., 2013; Leyton et al., 2012; Nappo et al., 2002). There is a restricted use of amphetamine-type stimulants (ATS) in Brazil due to the damage associated with its consumption (de Cássia Mariotti et al., 2013). Illicit commerce and counterfeit stimulants are responses to the use restriction which puts

public health at risk and mobilizes drug manufacturing crime (de Cássia Mariotti et al., 2013).

A cross-sectional study that analyzed data collected from the Second Brazilian National Alcohol and Drugs Survey (II BNADS) focused on a subsample of 3,838 participants between the ages of 15 and 64 years old to explore lifetime use of ATS and use in 2016 (Massaro et al., 2017). Results showed 4.1% of participants reported lifetime ATS use, 4.5% women and 3.8% men (Massaro et al., 2017). Of participants living in rural areas, a lower prevalence of both lifetime use and use in 2016 was significantly lower, with rates significantly higher (9.0% lifetime use and 4.6% 2016 use) in the central-west region of Brazil than four other major regions (Massaro et al., 2017).

Hallucinogens. Boiteux (2011) notes the legal prohibition of amphetamines and hallucinogens in 1967. However, Brazil ranks 6th among the countries with the greatest number of seized ecstasy-related manufacturing facilities (UNODC, 2017). Although there is limited data on the development of the ecstasy market in Latin America, samples from 150 different ecstasy tablet seizures in São Paulo, Brazil showed a strong trend of tablet adulteration, where 22% of the tablets had a presence of methamphetamine (Togni, Lanaro, Resende, & Costa, 2015; UNODC, 2017).

Adulteration of ecstasy tablets can lead to a number of difficulties and harm, including death and addiction. Information continues to emerge regarding ecstasy manufacturing and trafficking, however, one of the well-researched and most commonly abused substances is alcohol.

Alcohol. Although a legal substance for those over 18 years of age, alcohol consumption is a serious issue in Brazil and demonstrated through a variety of

nationally conducted research. For instance, the average age a Brazilian first drinks alcohol is 12.5 years and binge drinking is the most common form of drinking for adolescents (Pechansky et al., 2017). Out of 761 participants aged 14 to 19 years old, the Brazilian National Alcohol Survey reports, over 50% of the sample regularly use alcohol and out of every ten participants abused or were dependent on alcohol (Madruga et al., 2012). In an official estimation, the country annually spends 7.3% of its Gross National Product (GNP) on medical treatment and lack of work productivity due to alcohol use (Vendrame, 2016). From 2012-2016, the public health system of Brazil reported 313,000 alcohol related hospitalizations, costing US\$249 million annually (Vendrame, 2016). The toll alcohol has on the social environment is destructive to the Brazilian society (Vendrame, 2016). One of the largest alcohol-producing companies in the world, AB InBev, is simultaneously the largest tax paying company in Brazil generating approximately US\$3.8 billion in taxes annually compared to the US\$93 billion Brazil's government spends on alcohol problems (Vendrame, 2016, p.84). A company providing significant means for the government through taxes may have significant influence in the country's politics.

According to Caetano, Mills, Pinsky, Zaleski, and Laranjeira (2011), the consumption of alcohol among Brazilians is highly focused among a small group of heavy drinkers. In 2005, "the top 2.5% of the drinkers in Brazil consumed 14.9% of all alcohol consumed in the country in the past year, the top 5% consumed 27.4% and the top 10% consumed a little less than half (44.2%)" (Caetano et al., 2011, p.63). The study's results also suggest that minors, under the legal drinking age comprise of 6% of the alcohol consumers (Caetano et al., 2011) Additionally, shown in the first

representative study done in Brazil surveying binge drinkers, there is a significantly wider age range of adult binge drinkers in Brazil than reported in other countries (Sócrates Castro et al., 2012). Binge drinkers may be at an increased risk of addiction, auto accidents, involvement in crime, family violence, and absenteeism (Sócrates Castro et al., 2012). Sócrates Castro et al. (2012) insinuate that their findings should assist in the creation of public health policies that gear toward the prevention and treatment of alcohol-related issues.

Fortunately, abstinence from alcohol is on the rise, according to Lanna et al. (2014), data collected from 2,190 adults ages 18 and older showed that 30.6% of the men and 56.1% of the women who participated abstain from drinking alcohol. When separating the responses by religious affiliation, Pentecostal evangelicals were 7.3 times more likely to have never drunk, other evangelicals 4.4 times, and Protestants 6.3 times more likely than participants with other or no religious affiliation (Lanna et al., 2014).

Conducted in Porto Alegre, researchers collected data from 557 men and women, 60 years old or more, in a cross-sectional study demonstrating the prevalence of alcohol use in seniors (Guidolin, da Silva Filho, Lopes Nogueira, Pascoal Ribeiro Junior, & Cataldo Neto, 2016). Of the participants, 12% reported a history of alcoholism, of which 3.1% were currently diagnosed with alcoholism, 9% had a past history of alcohol dependence, and 2.9% currently abused alcohol (Guidolin et al., 2016). Results from the study confirmed the prevalence of alcoholism in the Brazilian senior population.

A cross-sectional study of, the United States equivalent of, 9th grade students in public and private schools in all five regions of the country was conducted by Brazil's

Ministry of Health and the Brazilian Institute of Geography and Statistics (Carvalho Malta et al., 2014). Results showed that of the 3,004 schools and 4,288 classrooms analyzed, 66.6% of the students ages 13-15 years old have tried alcohol and 50.3% of those who tried alcohol admitted to drinking more than just one dose (Carvalho Malta et al., 2014). It was also noted that the highest occurrence of those who reported having tried alcohol was in the southern region (Carvalho Malta et al., 2014). The teenagers claimed easy access to alcohol at parties with friends, in their homes, at bars, and buying directly from stores (Carvalho Malta et al., 2014). Regarding alcohol consumption, 10.0% of “students reported having had problems with their families or friends, missing school or getting involved in fights because of drinking” (Carvalho Malta et al., 2014, p.209).

The abuse of alcohol in terms of drinking and driving is important to note when assessing the prevalence of alcohol use in Brazil, especially, since the country is one of the leaders in number of traffic accidents (Leopoldo, Leyton, & Garcia de Oliveira, 2015). Traffic-related fatalities were heavily associated with alcohol use before injury in a cross-sectional probability sample of 365 autopsies conducted in São Paulo of fatally injured adult victims (Andreuccetti et al., 2016). 30.1% of the autopsies had alcohol in their system with a mean blood alcohol concentration (BAC) of 0.11% w/v (Andreuccetti et al., 2016).

Ribeiro Campos et al. (2013) conducted a cross-sectional survey roadside and used questionnaires and breathalyzer data that reported the prevalence of drinking and driving in Brazil. Of the 4,182 randomly selected drivers, 3,488 (83.4%) completed the questionnaire and breathalyzer test. The data collected showed 24.6% of the

participants had detectable BAC, and 15.9% had a BAC above 0.6 g/l, the legal limit. Ribeiro Campos et al.'s (2013) study also indicated that drivers who claimed to use alcohol regularly were three times more likely to have tested positive on a breathalyzer.

Leopoldo et al. (2015) took a convenience sample of 684 truck drivers in São Paulo state to test for alcohol use and alcohol use combined with other drugs. The participants reported the following: 67.3% used alcohol in the previous 30 days, 26% binge drink, 34.6% drink heavily, and 9.2% were at risk of developing an addiction to alcohol. Participants who reported using multiple substances showed heavier alcohol use. Leopoldo et al. (2015) suggest monitoring the issue of drinking and driving because it creates serious challenges for the user and society. The use and abuse of alcohol is an evident issue for Brazil as is cocaine, the second most common substance abused.

Cocaine and crack. The primary cocaine destination in South America is Brazil (UNODC, 2017). From 2010 to 2015, Brazil was the most common non-European country to send shipments of cocaine to Europe in addition to Africa, and was reportedly responsible for 58% of the departure/transit of cocaine to Africa (UNODC, 2017). Approximately 2.2% of the Brazilian population, with highest rates in the south and southeast regions, use cocaine which makes it one of the largest consuming markets worldwide, second to the United States (Bonacim Duailibi, Ribeiro, & Laranjeira, 2008; Rigacci Abdalla et al., 2014). A study done in 2012 shows the rate of cocaine use, in Brazil alone, is equal to the rates of cocaine use in all other South American countries (0.6%) and all North American countries (1.6%) combined (Rigacci Abdalla et al., 2014; UNODC, 2012). Studies show a predominance of crack use among young adult males

who often experience a higher prevalence of comorbidities such as, anxiety, depression, and antisocial personality disorder (Zeferino, Fermo, Fialho, & Bastos, 2017).

Pillon et al. (2017) reported 4% of the Brazilian adult population experiment with cocaine at some point in life and 48% of those become dependent on crack cocaine. Health behaviors and wellbeing are significantly affected by cocaine and crack cocaine use and no significant differences were found between users unless other drugs were combined. However, results showed cocaine users were younger with 63.4% between the ages of 18 and 29 years old while 55.6% of crack cocaine and polysubstance users were between 30 and 49 years old. Based on the results, “clinical interventions for prevention and treatment of the use of cocaine and/or crack cocaine should generate specific changes to a healthy lifestyle, in addition to the current practice of addressing the minimization of the use of drugs” (Pillon et al., 2017, p.792).

A variety of factors can contribute to a person’s choice to begin substance use with family cohesion being one of those factors, at least in Brazil (Marchi et al., 2017). Marchi et al. (2017) evaluated the family environment of a sample of adult substance users in Brazil and determined that crack cocaine users seeking treatment have significantly less family cohesion than alcohol-only users. In comparison to individuals who only use alcohol, crack cocaine users experience weaker family ties and poorer family functioning, relative to personal commitment (Marchi et al., 2017).

Naravaez et al. (2015) investigated crack cocaine use and abuse as it relates to quality of life, social functioning, family structure, and treatment history in Pelotas, Rio Grande do Sul, by way of a cross-sectional population-based study of 1,560

participants. The use of crack cocaine significantly impacted the quality of life of participants, particularly their general and physical health. Crack users had higher truancy rates than non-users and were not as likely to be religious. Although crack users tended to more frequently utilize available health care, the participants were dissatisfied with the previously received care which could, in part, explain the high rate of treatment abandonment. Results from Naravaez et al. (2015) suggest that family management, general health, functioning, and quality of life may be crucial elements to focus on within the recovery of crack cocaine users.

One study by Gonçalves and Nappo (2015), qualitatively and individually assessed 27, predominantly male, participants with little education, living on the streets, and between the ages of 19 and 49 years old, who use crack cocaine in combination with cannabis. They reported using several methods to overcome the addiction or the problems caused by it, such as seeking help in religion, changing their social context by avoiding contact with other crack cocaine users, and combining crack cocaine with other drug use. In addition to combining crack cocaine with cannabis, it was also often noted to be combined with alcohol and at times hallucinogens or medications, like benzodiazepines, with the goal of increasing the pleasurable effects or decreasing the negative effects. The participants reported combining crack cocaine and cannabis to neutralize the effects of crack in order to regain some quality of life, such as, being able to sleep and feeling hungry (Gonçalves & Nappo, 2015).

A study conducted by Santos Cruz et al. (2013) in Rio de Janeiro (southeast) and Salvador (northeast) examined “social, drug use and health indicators of young street level crack users” which confirmed the “extensive socio-economic marginalization, crack

and poly-substance use, and unmet health and social service needs” (p.437) many of which can be found documented by other studies of crack use. Santos Cruz et al. recruited 160 crack using participants between the ages of 18 and 24. The study concluded a serious need for targeted prevention and treatment interventions to decrease the high mortality outcomes of the young and large substance using populations in the two capital cities (Santos Cruz et al., 2013). In addition to the interventions needed in Rio de Janeiro and Salvador, São Paulo is home to the largest open-air drug scene in Brazil that has experienced many attempts of intervention and has yet to reach long-term success.

Cracolândia. Brazil, in recent years, has been innovative in their approach to combating drug trafficking and drug use, especially in Cracolândia, the most densely populated drug scene in the largest Brazilian metropolitan city of São Paulo (Miraglia, 2016; Ribeiro et al., 2015). Cracolândia is evidently lacking effective policing strategies, law enforcement often aggravating the population and causing additional issues, and high unemployment levels (Miraglia, 2016; Ribeiro et al., 2015).

However, although additional effort is being made, joint research conducted by the Secretary of State of Social Development and the United Nations Development Program showed that the number of women frequenting Cracolândia doubled between 2016 and 2017, 16.8% (119 women) to 34.5% (642 women) respectively (Desenvolvimento Social, 2017; Programa Recomeço, 2017b). Interviews of 139 men and women between May 2016 and May 2017 revealed that 44% of participants want to stop using drugs and the factor predominantly associated with the motivation to stop using is to have a history of attempted treatment (Desenvolvimento Social, 2017). In

addition, the research found an average of 1,861 people frequented Cracolândia in 2017, compared to the 709 people in 2016, a drastic 160% increase (Desenvolvimento Social, 2017). Statistics provided by the study showed 14.3% of women were pregnant, 44.1% of women had experienced some form of abuse, physical and/or sexual, in their childhood, 70.6% experienced physical abuse in Cracolândia, and 40% inject drugs into their system (Desenvolvimento Social, 2017). Among substance abusers in the region studied, less than 33.6% were homeless before using drugs, and 42% claimed to have nobody to call in the case of an emergency (Desenvolvimento Social, 2017).

The complex problem in Cracolândia appears to be stronger than efforts being made by the government and other Brazilian organizations. Within a two-year timeframe, two significant initiatives - Recomeço (Restart) and De Braços Abertos (With Open Arms) - and many smaller works, were implemented to reduce Cracolândia's drug using population and succeeded with a temporary one-third reduction (Ribeiro et al., 2015). These two initiatives are explored further later in this chapter, though, next, sexual behavior as it relates to drug abuse is addressed.

Sexual Behavior and Drug Abuse

Risky sexual behavior is commonly seen among male and female substance users and consequences result in a variety of forms. Sexually transmitted diseases such as HIV are common and many substance users do not take precautionary measures against the virus, although many become sexually active before beginning to use substances (Pechansky et al., 2017). Furthermore, substance users that began using earlier in life are more prone to risky sexual behavior (Pechansky et al., 2017). And, Jessor and Jessor's (1977) problem behavior theory states that sexual relations

can indicate future risky behaviors such as unprotected sex and/or drug use (Pechansky et al., 2011). A frequently used strategy for obtaining drugs is through prostitution, which is commonly known to be a legal form of work in Brazil (Zeferino et al., 2017). Furthermore, “drugs, gifts or money in exchange for sex was more likely to be reported among early sexual debut respondents, when compared to late sexual initiators” (Pechansky et al., 2011, p.225) in a study conducted in Porto Alegre.

An observational study conducted in São Paulo evaluated the risk of sexual addiction among men and women diagnosed with substance dependence (alcohol and drugs) (Antonio et al., 2017). Antonio et al. (2017) reported that of the 139 participants, the majority were single, heterosexual, high-school educated, unemployed males in their late 30s; 44.4% participants indicated a primary use of alcohol and the sample included 55.6% crack/cocaine users and 39.1% polysubstance users. “Polysubstance addicts had a higher risk of sexual addiction than monosubstance addicts” (Antonio et al., 2017, p.418) and no significant variance between crack/cocaine and alcohol users in the risk of sexual addiction. Sexual addiction rates were reported to be higher among addicts than the general population. In addition, the results agree with the literature in regards to monosubstance users having lower rates of psychiatric comorbidities than polysubstance users (Antonio et al., 2017). Antonio et al. (2017) suggest a “possible explanation for the association between polysubstance and sexual addiction might be the influence of socio-cultural contexts where sex, drugs, and alcohol are connected” (p.419). Precarious sexual behavior is common among substance abusers in addition to mental health issues.

Mental Health and Drug Abuse

Learning challenges, financial and family problems, and trouble maintaining a job are a few of the many issues related to substance use and abuse (Santos Cruz & Felicissimo, 2017). In addition, there is a wide range of mental health issues and behavioral problems that are at times comorbidities of substance abusers, such as personality disorders and conduct disorders. The following also explores the reality of violence among substance users, particularly intimate partner violence in Brazil.

Krieger et al.'s (2016) study on personality disorders (PD) shows high rates among 101 drug use inpatients in two hospitals, São José Clinic and Parque Belém Hospital in Porto Alegre. Data was collected between March 2013 and December 2014 with a 6-months follow-up period. 55.4% of the participants were diagnosed with PD (14.9% avoidant, 11.9% borderline, and 8.9% antisocial). Participants with PD were more likely to have used crack early in life and received significantly more recovery treatments than those without PD. After the six-month follow-ups were conducted, researchers concluded that no statistically significant changes occurred regarding substance use or treatment adherence. Krieger et al. (2016) concluded that "patients with SRD (substance related disorders) and PD need the identification of this comorbidity and of their personality characteristics in order to plan a more comprehensive and effective treatment" (p.127).

In addition to PD, Pachado et al.'s (2015) discussion on Conduct Disorder (CD) shows it too is a serious condition that can harm the individual and community. In a cross-sectional sample of 720 participants, adult crack users from outpatient and

inpatient treatment facilities in Brazil showed a high prevalence of social anxiety (22.9%), alcohol abuse (12.8%), and lifetime psychotic symptoms (36%) (Pachado et al., 2015). Average age of participants was lower for those with CD than those without CD symptoms. Individuals with CD symptoms had a more significant relationship with violence, trauma, and crime. Pachado et al. (2015) suggest using the study results to guide therapeutic strategies, due to the conclusion that “crack users with CD are at risk of committing violent actions and...exposed to traumatic situations” (p.169) which compound their circumstance.

II BNADS reported that about 9.3% of Brazilians have been victims of urban violence, at least one time (Rigacci Abdalla et al., 2018). Among substance users, the likelihood of being a victim of violence more than doubles on average. 19.7% of cocaine users and 18.1% of participants with alcohol use disorders have experienced urban violence and odds of a substance using individual being the aggressor in a violent situation almost quadruples (Rigacci Abdalla et al., 2018). It is evident that substance use negatively impacts society based on this study alone.

It is also common for male substance users to commit Intimate Partner Violence (IPV), actions that are violent or abusive between ex/current-partners (Gilchrist, Radcliffe, Noto, & d'Oliveira, 2017). Several factors are consistent among ever perpetrating IPV in Brazil such as increased anger expression and depressive symptoms, and physical fighting with another man within the past 12 months, according to a cross-cultural comparison between Brazil and England (Gilchrist et al., 2017). Of the 223 Brazilian participants from public health system funded outpatient community substance use services in São Paulo, 86% of participants were receiving treatment for

alcohol and 57% for drugs (Gilchrist et al., 2017). A shocking 18% strongly agreed with the statement, “if a woman doesn’t physically fight back it’s not rape”, and 29% strongly agreed, “that a woman cannot refuse to have sex with her husband” (Gilchrist et al., 2017, p.47), with each statement being strongly agreed with by only 4% of the population from England. One way to reduce emotional and physical IPV perpetration is to reduce substance use (Stuart, O’Farrell, & Temple, 2009).

Ally et al. (2016) compared 2006 and 2012 prevalence rates of IPV using data from two Brazilian Alcohol and Drugs Surveys. Prevalence rates significantly decreased between 2006 and 2012 data, especially among women 8.8% and 6.3%, respectively, of IPV victimization (Ally et al., 2016). Fortunately, rates of IPV perpetration decreased significantly as well, 10.6% in 2006 to 8.4% in 2012 and rates of bidirectional violence (3.2 to 2.4%) (Ally et al., 2016). When alcohol was a factor, the likelihood of being a victim increased and was 4.5 times more likely if the perpetrator was using illicit drugs (Ally et al., 2016). Disregarding the significant reduction in most types of intimate partner violence, the national rates remain high and the study again confirms a positive relation between substance use and IPV (Ally et al., 2016). This section concludes the overview of the current drug situation in Brazil, providing insight into the profile and characteristics of individuals who struggle with substance addiction. The following portion outlines the government’s response by way of drug-related policies.

Brazilian Drug Policy

Since the 1990s, Brazilian drug policy has significantly evolved, in 1998 a new health coverage system was implemented, and the Mental Health System Reform shifted health services to community-based networks. In terms of health coverage, the

Unified Health System (Sistema Único de Saúde, SUS) is free of cost to everyone in Brazil, including non-citizens (Garcia et al., 2017, p.129; Ministério da Saúde, 2018a). In addition, Federal Law 10.216/2001 guarantees the rights of persons with mental disorders, including disorders related to the use of psychoactive substances (Garcia et al., 2017, p.129). The following highlights the SUS user rights and therefore, under the law a person should:

1. Have access to the best treatment of the health system, according to their needs;
2. To be treated with humanity and respect and in the exclusive interest of benefiting their health, aiming to achieve their recovery by insertion into the family, work and community;
3. Be protected from any form of abuse and exploitation;
4. Have confidentiality of information provided;
5. Have the right to medical presence, at any time, to clarify the necessity or otherwise of involuntary hospitalization;
6. Have free access to available media;
7. Receive as much information as possible in respect to one's illness and treatment;
8. Be treated in the therapeutic environment by the least invasive means possible;
9. Be treated, if possible, in community mental health services. (Garcia et al., 2017, p.129)

Although comprehensive, further research is needed that explores whether or not these rights are properly implemented throughout the SUS.

SUS patients that present a need for mental support are directed toward the Network of Psychosocial Attention (Rede de Atenção Psicossocial, RAPS) that provides a variety of integrated support for the wellbeing of those with mental health issues, including those experiencing the effects of crack, alcohol, and other drugs (Antunes da Costa et al., 2015; Garcia et al., 2017; Ministério da Saúde, 2018b). CAPS are the RAPS component that appears to receive the most attention from researchers in addiction recovery. As of 2014, CAPS units were placed in 1413 Brazilian cities with 2209 units available (Antunes da Costa et al., 2015). Psychosocial Care Centers for Alcohol and Drugs (CAPS-AD) is one type of CAPS service that pertains specifically to alcohol and drugs users (Antunes da Costa et al., 2015). Additionally, the subsequent are the three types of psychiatric hospitalization available and defined by Brazilian legislation as the following:

1. Voluntary Hospitalization: the user requests or consents to their hospitalization and has the right to request at any time his/her suspension.
2. Involuntary Hospitalization: consent is not given by the user but at the request of a third party. In this case, the hospitalization must be communicated to the Public State Department (Ministério Público Estadual) by the party responsible for the admittance, and this procedure must be adopted when discharge occurs. In this case, the family has the right to request the suspension of the hospitalization at any time.

3. Compulsory Hospitalization: determined by the Justice Department (Justiça).
(Garcia et al., 2017, p.132)

With the severity of substance abuse issues, research and public policies to make further adjustments to the present ineffective system are very scarce (Pereira et al., 2017). For instance, a lack of alcohol regulation has contributed to the declining health of the Brazilian population, regulations are weak and poorly enforced and could be related to the aforementioned possible influence the alcohol industry has on the government (Laranjeira & Sendin Mitsuhiro, 2011). When the new federal constitution was enacted in 1988, alcohol advertisements were to be regulated by law (Moreira, 2005). However, the Congress was enticed to further interpret and clarify the law to refer to only alcoholic beverages with greater than 13 degrees of concentration Gay-Lussac, therefore, commercials for beer and wine are no longer included as alcoholic beverages for marketing purposes, due to their “low alcohol content” (Brazilian Congress, 1996; Carvalho Malta et al., 2014; Noel, Lazzarini, Robaina, & Vendrame, 2016; Vendrame, 2016). This ruling means continuous marketing exposure to children and adolescents. Self-regulation is not only defined but applied and managed by the Brazilian “advertising industry’s National Council for Self-Regulation in Advertising” (Noel et al., 2016, p.59) and the “Code of Self-Regulation in Advertising” (p.59).

Many see the advertising industry’s self-regulating abilities as a way to maintain freedom of speech and guard the industry’s interests (Noel et al., 2016). But, in 2012, “the Attorney General of the Republic filed a lawsuit” (Noel et al., 2016, p.59) of unconstitutionality by omission with the Brazilian Supreme Court at an attempt to change the degrees of concentration to “0.5 degrees Gay-Lussac; however, the lawsuit

was ultimately dismissed” (Noel et al., 2016, p.59). The case was a missed opportunity for the Supreme Court to launch public policies founded on evidence and ones that could decrease the impact marketing has on harmful use of alcohol (Caetano et al., 2011; Supremo Tribunal Federal, 2015; Vendrame, 2016).

Ribeiro et al. (2015), suggest a combination of policies are needed to improve the current addiction situation, especially in Cracolândia (Crackland), an open-air drug scene, previously discussed, that is the “most densely populated” (p.571) and oldest drug scene in Brazil, “in order to reduce drug supply and increase treatment availability and social and housing support” (Miraglia, 2016, p.572). Their suggestions are based on research in Brazil and the success other countries have had in dealing with open drug markets and the prevention of future endeavors (Ribeiro et al., 2015). In further international comparison, Ribeiro et al. (2015) determined three aspects that are “dangerously absent in Brazilian drug policy on open-air drug scenes”:

1. The recognition that open-air drug scenes are particularly problematic, therefore formal guidelines and comprehensive interventions are needed to improve the wellbeing of drug users and also of the wider community.
2. The establishment and support of organizations responsible for understanding the needs and particularities of the open-air drug markets, as well as searching for solutions, with full involvement of representatives of users, health care, social care, justice and public security and government.
3. The development of an integrated action plan with attainable targets and involving health care, social services and police agents. (p.572)

The recognition, establishment, and development of the aforementioned elements would be, according to Ribeiro et al. (2015) the most productive way to move forward in transforming Cracolândia.

It is essential that Brazil's public policies are integrated jointly with all sectors involved, including education, justice, health, and general society (Gabatx et al., 2013). In response to the high levels of violence and substance abuse in Brazil, Public Sector Senior Specialist, Miraglia (2016) recommends those who influence and make policy changes, look into criminal organizations, the justice system, and prevention (2016). Regarding evolving criminal organizations, leaders should assess their business models and how they integrate and influence the community. Furthermore, Miraglia (2016) recommends several changes for the justice system to consider: reform of the current criminal justice system and stronger public legal aid; police reform to place additional accountability and oversight in response to police brutality, lethality, and ineffectiveness; a culture shift of the judiciary punitive approach to imprisonment; and development of efficient and reliable alternatives to imprisonment.

There are two dominant forces governing Brazilian prisons – gangs such as the Comando Vermelho, one of the main criminal groups in the drug trade, and Pentecostal prison churches led by inmates (Johnson & Densley, 2018; Miraglia, 2016). The prison church is only working “as a viable alternative to the gang because it has achieved legitimacy in the eyes of gang members” (Johnson & Densley, 2018, p.258).

Traditionally, prisons in Brazil have been occupied by people who committed property crimes, however, due to the increased sentencing for drug trafficking, penitentiary space has increased, primarily with lower class small-time drug dealers (Boiteux, 2011).

The relationship between drug policy and prison is a reflection of the insistence of governments on adopting policies that are destined to fail at achieving their stated aims, or else it reflects the success of these policies that at achieving hidden or undeclared goals of increasing repressive social control of the poorer segments of the population, who are subjected to rights violations and degrading treatment in Brazilian and Latin American prisons. (Boiteux, 2011, p.37)

The final recommendations Miraglia makes are to aggressively enforce gun regulations that are needed to impact the substantial illegal arms market and increase funding for local government crime prevention strategies (Miraglia, 2016). Implementing these changes into Brazil's national approach to drug policy could positively impact not only Brazil but influence countries undergoing similar issues worldwide.

Addiction Recovery Options

Brazil has a growing young population and emerging economy, yet a shortfall in regard to mental health care and social services which Massaro et al. (2017) claims led to the rise of preventable and foreseeable public health issues. In response to substance abuse issues currently confronting Brazil, one must consider the programs, facilities, and other organizations present that are addressing these challenges to have a full understanding of the situation and before strategizing change initiatives. Five state capital cities, Porto Alegre included, reported alcohol as the drug that most commonly motivated men and women to seek treatment (Faller et al., 2014). For a person ready to seek help through recovery treatment, what are the recovery options in place?

RAPS. The RAPS consist of resources related to basic health care, strategic psychosocial attention, transient residential care, hospital care, deinstitutionalization

strategy, and psychosocial rehabilitation strategy, as outlined below (Garcia et al., 2017, p.133-139):

Basic Health Care

- *Family Health Strategy (ESF)*. Aimed at serving areas with approximately 3000 to 4000 inhabitants, ESF teams are comprised of a general practitioner, a nurse, a nurse technician, and a community health agent, that provide comprehensive health care.
- *Family Health Support Center (NASF)*. Working in conjunction with ESF teams, NASF teams are comprised of professionals from various fields of knowledge (including psychologists, social workers, occupational therapists, psychiatrists, etc.) who offer specialized support in case discussion and shared patient care which may include working with situations related to mental health and drug-related problems.
- *Street Doctor Team*. Multi-professional teams that provide health care to the homeless population.
- *Center for Coexistence and Culture*. A center for promoting health care, psychosocial rehabilitation processes, and creating a space for social solidarity, fostering sociability, production, and intervention in culture and in the city.

Strategic Psychosocial Attention

- *Psychosocial Care Centers (CAPS)*. Multidisciplinary teams specialized in mental health care services working to primarily support individuals with severe or persistent suffering or mental disorders. Various modalities of

CAPS exist: CAPS I, II, III, Alcohol and Drugs (CAPS-AD), and Pediatrics (CAPSi).

Transient Residential Care

- *Home Units.* A residential healthcare environment with 24-hour health services for vulnerable populations with drug or alcohol problems requiring care for up to six months for individuals as young as 12.
- *Attention Services in Residential Regime (Therapeutic Communities).* Transitional residential environment, typically lasting between nine and twelve months, for adults with stable clinical needs surfacing from the use of alcohol and drug abuse, often receiving individuals from CAPS.

Hospital Care

- *Emergency Mobile Service (SAMU).* Mobile emergency care, including mental health care.
- *Emergency Care Unit (UPA).* Prompt attendance provided for emergency situations, including mental health care.
- *Hospital Service or Specialized Hospital in General Hospital.* Regulated according to clinical criteria through the administrative center or CAPS, beds are available for individuals qualified to be admitted into the general hospital for mental health purposes.

Deinstitutionalization Strategy

- *Therapeutic Residential Service.* Dwellings provided in the community that aim to guarantee long-term patients of psychiatric hospitals and the Custody and Psychiatric Treatment Hospitals.

- *“Return Home” Program.* Instituted by law 10.708/2003, this social inclusion program aims to contribute to and strengthen the processes of deinstitutionalization.

Psychosocial Rehabilitation Strategy

- *Psychosocial Rehabilitation Strategy.* Initiatives aimed at the generation of work and income, including solidarity enterprises, social cooperatives, and solidarity housing, for individuals with mental disorders or needs arising from substance use.

Based on the range of public services offered by the government for substance users, the challenge for treating substance users remains. Schein and Prati (2013) state user demands must be acknowledged and taken into consideration within the operation of the aforementioned services and additional treatment approaches are needed to attend to addicts and their families. The study suggests the general hospital is the best therapeutic strategy, however, professionals need additional specializations and greater commitment to the patients, which is evidently lacking (Schein & Prati, 2013).

CAPS-AD. Over 400 services of CAPS-AD, a public resource provided under RAPS, are available but need to be improved according to Donatti Gallassi, Nakano, Wagner, de Oliveira Silva, and Fischer (2016). Their study examines characteristics of CAPS-AD clients in a suburb of the country’s capital, Brasília, and show participants were mostly middle-aged unemployed males who use alcohol or a form of cocaine and about half the participants have prior substance abuse treatment which was mostly externally motivated rather than self-initiated. Participants suggested reasons for treatment discontinuation with significant association with employment and education

status; and services appear to attract individuals without prior treatment history. Finally, 60 percent of participants provided specific ideas on how to improve CAPS-AD services which showed the majority agree and recommend increasing emotional or social support in treatment services (Donatti Gallassi et al., 2016).

One study assessed the sociodemographic and clinical profile of individuals who have used CAPS-AD in Curitiba, Parana, a metropolitan city in southern Brazil (de Oliveira et al., 2017). Similar to demographics shown in the previously discussed study, this study shows that of 163 participants, the majority were male, single, had not completed elementary education, were unemployed, alcohol was their drug of choice, and their household had between one- and three-monthly minimum wage incomes. Psychiatric comorbidities and family history of substance use disorders were shown among the majority (de Oliveira et al., 2017).

With any large organizational system comes diverse challenges. Xavier and Monteiro's (2013) study supports this statement in a 2013 study that determined the government should increase the number of CAPS that operate over 24 hours and extend CAPS-AD hours in order to reduce the overloading occurring in emergency centers. Additionally, CAPS-AD professionals need increased training, including refresher courses and related conferences, and professionals with higher qualifications. Through the conducted research, it was determined that the CAPS-AD units are siloed and function independently from other RAPS units, furthermore, there lacks consensus on therapeutic treatment for crack users. It appears that approaches used in treatment are the same no matter the type of drug a person uses, yet studies show treatment should be individualized due to the complexities involved. Each individual's experience

with substance abuse is different (cocaine, alcohol, heroin, poly-substance use, etc.), comorbidities vary, and their lived experience overall is individualized, therefore individualized treatment plans would make sense (Xavier & Monteiro, 2013). Although facing many challenges, the services that CAPS-AD offers are incorporated into other recovery efforts such as Programa Recomeço.

Programa Recomeço. Programa Recomeço was launched in May 2013 by the Government of São Paulo state by installing tents and mobile offices inside Cracolândia to offer a number of services to the addicted and homeless population: showers, bathrooms, barber-shops, a sports center, workshops and training opportunities, detoxification units, and housing centers (Ribeiro et al., 2015). All of the services are directly connected with an addiction treatment center located near Cracolândia, called the Reference Center for Alcohol, Tobacco, and Other Drugs (CRATOD). CRATOD provides two services to the local population, an outpatient unit (CAPS-AD) and an emergency care facility.

As of 2018, Recomeço remains open with over 3,300 vacancies throughout the state of São Paulo in the areas of internal care, detoxification, therapeutic communities, and halfway houses (Programa Recomeço, 2017a; Programa Recomeço, 2018). The program's Hospital Recomeço, in Botucato, is the first public hospital in São Paulo state specifically designed to treat and rehabilitate substance abusers and addicts, especially users of crack (Programa Recomeço, 2017a; Programa Recomeço, 2018). The hospital is divided into 7 departments and has 66 beds for detoxification patients. An additional program of Recomeço, Recomeço Família (Family Restart), by way of the Center for Citizen Integration (CIC), assists families by providing guidance in how to be prepared

and best support the recovery and reintegration of a substance abusing family member (Programa Recomeço, 2017a).

Programa Recomeço opened its first halfway house, or *casa de passagem*, in São Paulo for substance abusers in 2017 to support men older than 18 years (Programa Recomeço, 2017c). The halfway house has 24 vacancies and receives men for a maximum of 30 days (Programa Recomeço, 2017c). The São Paulo state government annually invests \$1 million Brazilian reais, approximately \$298,000 U.S. dollars, to support Programa Recomeço with these efforts (Programa Recomeço, 2017c). An additional recovery program in São Paulo is called Braços Abertos.

Braços Abertos. In 2014, the second significant initiative was implemented, Braços Abertos. This Municipality Program directs its efforts towards the homelessness and unemployment in Cracolândia (Ribeiro et al., 2015). The organization offers accommodation to drug users in nearby hotels and aids the unemployed in finding healthy employment (Miraglia, 2016; Ribeiro et al., 2015). Braços Abertos' social reintegration tactics include providing healthcare to addicts, temporary housing, food, technical training, and gynecological services to all women interested (Miraglia, 2016). One month after the commencement of Braços Abertos the municipality claimed the initiative reduced the use of crack in Cracolândia by about 70% and 89% of those participating in the job placement program had maintained their position (Brito, 2014). Simultaneously, in the first month, Braços Abertos partnered with the São Paulo Municipal Guard who apprehended 4,000 people and imprisoned 25 people which correspondingly and significantly contributes to the extremely high decrease of crack use (Brito, 2014; Miraglia, 2016). Miraglia (2016) claims the initiative lacks robust

evaluations and faces a critical challenge of treatment adherence. However, significant progress has been made, and support continues. In addition to locally grown efforts such as Programa Recomeço and Braços Abertos that operate in São Paulo state, another recovery option, that is spread throughout Brazil is an addiction recovery model called a therapeutic community.

Theoretical Framework: Therapeutic Communities

Therapeutic communities were introduced in Brazil, the United States, and other countries, as an alternative to psychiatric treatment in hospitals and clinics (Kaplan & Broekaert, 2003; Ribeiro et al., 2013). In 1958, Charles Dederich and other former substance abusers founded Synanon in California, the original contemporary therapeutic community model that considered itself a social movement, evolved into a religious cult, and closed its doors in 1991 (De Leon, 1995; Kaplan & Broekaert, 2003; National Institute on Drug Abuse, 2015). Glaser (1981) claims Synanon can be traced “through Alcoholics Anonymous to the so-called Oxford Group” (p.13) which has a strong connection to the Protestant Reformation. In 1964, after extensive research was conducted on Synanon, Daytop Village, now called Samaritan Daytop Village, opened in New York. However, the Daytop Village model for addiction recovery intentionally focused on broader social impact, equipping residents “to fight the spreading epidemic of drug addiction” (Kaplan & Broekaert, 2003, p.205).

Therapeutic communities have significantly evolved since Synanon and Daytop Village were established, adapting to environmental changes and growth (De Leon, 1995). In 1995, De Leon identified the need for a theoretical framework for therapeutic communities in order to “advance research and guide training, practice, and program

development” (p.1604), especially due to the complex addiction recovery process and the variety of programs.

As of 2008, over 65 countries have implemented therapeutic communities (Bunt, Muehlbach, & Moed, 2008). The principal factors found among therapeutic communities internationally are (a) “the role of the treatment community as the primary agent of client change” and (b) “the distinct therapeutic structure” (Bunt et al., 2008, p.81). The therapeutic community framework, although founded in the United States, has proven to leave sufficient room for organizations to adapt the core practices to cultures around the world (Bunt et al., 2008). Ribeiro et al. (2013) posit there are three main pillars for Brazilian therapeutic communities: “voluntary admission, social interaction with peers, and spirituality” (p.16).

In Brazil, one may find a therapeutic community affiliated with a national association that, typically, offers professional courses for addiction recovery workers and others interested in gaining a better understanding of chemical dependence. The most common and seasoned association is FEBRACT, headquartered in Campinas, São Paulo, that promotes De Leon’s therapeutic community principles (FEBRACT, n.d.) and since 2001 follows guidelines established by ANVISA (Ribeiro et al., 2013). IPEA’s (2017) findings show 21.4% of a wide-ranging therapeutic community sample are affiliated with FEBRACT. However, the majority of therapeutic communities are “not affiliated with FEBRACT, maintain poor hygiene, are badly organized, and have no treatment guidelines. Some of those facilities are run based on strictly religious principles, while others use physical force and solitary confinement as punishment” (Ribeiro et al., 2013, p.16). The SDSTJDH, an association specific to Rio Grande do

Sul, consists of private and not-for-profit organizations, financed in part by the state government. Affiliates of SDSTJDH are open and exclusively voluntary-based institutions with programs lasting up to 12 months (SDSTJDH, n.d.). During residence, individuals are to maintain their treatment in the psychosocial care network and other services, as needed (SDSTJDH, n.d.). Other common associations are Confederação Nacional de Comunidades Terapêuticas (CONFENACT), Federação Norte e Nordeste de Comunidades Terapêuticas (FENNOCT), Federação das Comunidades Terapêuticas Evangélicas do Rio Grande do Sul (FECTERS), Associação Catarinense de Comunidades Terapêuticas (ACCTE), Federação Nacional das Comunidades Terapêuticas Católicas (FNCTC), and Comunidades Terapêuticas em Rede (COMTER) (IPEA, 2017).

Legislation. The therapeutic community federations in Brazil typically partner with or stem from government initiatives. FEBRACT, for instance, partners with the São Paulo state government in the construction of public policies, financed by the state's drug policy program, to monitor and provide support and resources to services of Programa Recomeço and other organizations (FEBRACT, n.d.c). However, the majority of therapeutic communities are not affiliated with a federation and are not in a position to make a significant impact on public policy. Therapeutic communities in Brazil are typically located in rural areas and isolated as a part of the addiction recovery method (Pereira et al. 2017). However, the isolation and lack of national treatment protocols for professionals working in the field of addiction further silos the unaffiliated therapeutic communities and leaves their leadership to determine how to measure their effectiveness, be accountable, and aware of best practices (Ribeiro et al., 2013).

Outside of Brazil, scholars and practitioners are contributing to the literature on therapeutic communities, and although there are commonalities among countries, regulations vary. Gómez-Restrepo et al. (2018) conducted a study that demonstrates therapeutic communities in Brazil, Argentina, Mexico, Peru, and Colombia have more in common than different. Therapeutic communities individually impact society, but collectively the organizations have the potential to create broader and more effective systemic change (Hanleybrown et al., 2012). The World Federation of Therapeutic Communities (WFTC) is an international therapeutic community federation that connects therapeutic communities and provides guidance and resources to its members. In recognition of the lack of funding organizations tend to experience, the WFTC encourages policymakers to support therapeutic communities and advocate for the essential role of these organizations in society (WFTC, n.d.). “Today, governmental control and adherence to standards such as the standards and ethics code formulated by the WFTC provide a general framework for [therapeutic community] professionals” (Vanderplasschen, Vandeveld, & Broekaert, 2014, p.66).

Vanderplasschen et al. (2014), on behalf of the European Monitoring Centre for Drugs and Drug Addiction, reviewed therapeutic communities throughout Europe and determined that concept-based and hierarchical therapeutic communities are the longest standing addiction treatment model. Vanderplasschen et al. (2014) note that European therapeutic communities are more focused on operating with trained professionals, unlike what is common in the United States and Brazil where former substance abusers often fill staff positions. They further suggest that detailed standards are needed for therapeutic community operations, such as the Service Standards for

Addiction Therapeutic Communities established by the Community of Communities (Vanderplasschen et al., 2014). The Community of Communities being a therapeutic community network that unites organizations in the United Kingdom and internationally (Royal College of Psychiatry, 2015).

In the literature, the specific practices and methods utilized regarding therapeutic communities in Brazil are nascent. However, internationally, in locations such as Australia, New Zealand, and the United Kingdom, best practices for service standards that are implemented have been more broadly disseminated and evaluated. The set of standards the Community of Communities created have been thoroughly evaluated and offer participating organizations an outlet to share best practices (Royal College of Psychiatry, 2015). In New Zealand, De Leon's 'community as method' is employed by therapeutic communities (Matua Raki, 2012). In recent years, New Zealand's organizations have adapted to the shifting environments and now tend to operate as modified therapeutic communities that serve specific populations, with all staff training conducted internally because specific training available externally is almost non-existent (Matua Raki, 2012). While practices implemented in other countries may not directly translate to the Brazilian context, there is value in what can be learned from international organizations for therapeutic communities in Brazil to more effectively operate.

Organizational Operations. Community is the quintessential component of therapeutic communities (De Leon, 1994). They are distinguishable from other addiction recovery approaches due to the "purposive use of the community as the primary method for facilitating social and psychological change in individuals" (De Leon, 1994,

p.22). Recovery in therapeutic communities is (a) approached as a developmental process, (b) dependent on an individual's motivation and readiness to change, (c) readily available, but not *provided*, to the residents through the service providers, other residents, and "the daily regime of work, groups, meetings, seminars, and recreation," (p.21) and (d) is built on social learning to change negative behaviors (De Leon, 1994). De Leon's (1994) community-as-method model for therapeutic communities includes the use of the following attributes (p.22-23):

- Resident roles
- Resident feedback
- Resident as role model
- Collective design for learning
- Shared norms and values
- Structure and systems
- Open communication
- Internal relationships
- Balance between community and resident

"Residents participate in the management and operation of the community" (Gowing, Cooke, Biven, & Watts, 2002, p.10) and through self-help and mutual support, the community "is the principal means for promoting behavioral change" (p.10). Another consistent attribute among therapeutic communities in various settings is that "there is a focus on social, psychological and behavioral dimensions of substance use, with use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of health living" (Gowing et al., 2002, p.10).

Gómez-Restrepo et al. (2018), evaluated the quality of 176 therapeutic communities in Argentina, Brazil, Colombia, Mexico, and Peru using the widely accepted criteria established by De Leon. Findings show 70% of the therapeutic communities overall, 85% of Brazilian organizations, met 11 or 12 out of the 12 criteria assessed. More than half of the organizations participating from Brazil met all 12 criteria evaluated (Gómez-Restrepo et al., 2018).

De Leon (1994) recommends services for treatment and education should be provided within a community environment to be effective. Excluding individual counseling, the day-to-day schedule in a therapeutic community should be organized in a collective format, aligning with the leadership style. The strategy implemented should consist of a structured day, work as a form of therapy, and educational activities, all following a phase format (De Leon, 1994).

De Leon (1994) suggests a three-stage program with several stages incorporated into each stage. Stage 1, the induction, focuses on the assessment and orientation of the resident and lasts up to 60 days. Stage 2 consists of the primary treatment and concentrates on social and psychological goals, lasting months 2 to 12. During Stage 1 and Stage 2, structures need to be in place to effectively facilitate group meetings in a safe environment, and each resident should have an individualized plan catered to their therapeutic and educational needs (Royal College of Psychiatry, 2015). Lastly, Stage 3 prepares the resident for reentry and reintegration into society. This stage consists of two phases, the first during months 13 to 18 where “the main goal is preparation for healthy separation from the community” (p.43). Residents remain living in the therapeutic community but leave to attend school or work. The second phase of

Stage 3, during months 18 to 24, is when residents move forward in their studies or work and live independently from the therapeutic community, typically with peers. Individuals “may attend aftercare services such as Alcoholics Anonymous or Narcotics Anonymous or take part in family or individual therapy” (p.43). This final phase is observed as the end of residency. However, continued participation in the therapeutic community’s activities and the community itself is encouraged. Research and clinical evidence show long-term residential therapeutic community operations lasting 18 to 24 months are ideal. However, due to the increasing complexities of substance abusers, longer periods of immersion in therapeutic communities may be required. For therapeutic communities with shorter durations, the length of each of the three stages is reduced, but the goals remain the same (De Leon, 1994).

Where independent therapeutic communities are at their liberty to determine the length of treatment, some therapeutic community federations set the minimum or maximum length of treatment for the affiliated communities. Although FEBRACT does not explicitly publicize requirements on the length of time, SDSTJDH affiliates have programs lasting up to 12 months (SDSTJDH, n.d.). Furthermore, technical visits are required to become affiliated with FEBRACT, consisting of an institutional evaluation that, when necessary, is followed by an Institutional Intervention Project, a customized plan to demonstrate areas where improvements are needed in order to become an affiliate (FEBRACT, n.d.b).

Program evaluation is an essential component to assess the effectiveness of any therapeutic community which there are tools available for support, such as questionnaires based on the Survey of Essential Elements Questionnaire (SEEQ) and

the Modified Essential Elements Questionnaire (MEEQ) that consists of several SEEQ components (Gowing et al., 2002). To evaluate the effectiveness and assess the value of services provided by therapeutic communities, Gowing et al. (2002) suggest a systematic process comprising the following steps:

Reflecting on current program practice; gathering information about current practices and the impacts of such practice; analyzing the information gathered; reaching conclusions on the basis of this analysis; and planning, modifying and improving practices on the basis of these conclusions. (p.12)

Therapeutic communities in an organizational sense tend to lack clear technical and ethical parameters yet possess strong religious influence (Roncati Guirado & Isicawa, 2018).

Spirituality. “Religion has served as an important resource for treatment against drug addiction, since faith provides better quality of life as it brings in hope” (Pedrosa, Reis, Gontijo, Teles, & Medeiros, 2016, p.904). Participation in a religious group is an indicator used by FEBRACT to gauge the quality of life of residents from their affiliated therapeutic communities (Roncati Guirado & Isicawa, 2018). For individuals working towards sober-living, “spiritual beliefs may provide moral values and emotional support, offering comfort in times of stress and adversities” (Naravaez et al., 2015, p.217). In rural locations, spiritually-based therapeutic communities are helpful alternatives when conventional healthcare may not be available; and some see spiritually-based recovery as an adjunctive route to traditional healthcare (Beraldo et al., 2018). Aftercare is an additional aspect of recovery that may involve spirituality or religion.

Aftercare. An essential component of post-recovery health is aftercare. Aftercare combined with the length of stay in treatment is a predictor of recovery status (Vanderplasschen et al., 2013). Furthermore, aftercare services are capable of reducing substance use, delaying relapse, decreasing stress and improving the individual's overall quality of life (Arbour, Hambley, & Ho, 2011; Duffy & Baldwin, 2013; Laudet, Morgan, & White, 2006; Sannibale et al., 2003). Sannibale et al. (2003) conclude that of the 77 participants studied, structured aftercare, as opposed to unstructured aftercare, reduces the rate of substance use by one-third and it is four times more likely an individual has not relapsed during the first six months post-treatment. Aftercare may take place at the therapeutic community where the individual resided, through programs such as AA, or other support groups (De Leon, 1994; Duffy & Baldwin, 2013). Moreover, Duffy and Baldwin (2013) report several study participants equated missing an aftercare meeting with relapse.

'When you sit there you hear stories of people, what they were going through, in the madness, when they were using, drinking or drugs like. You relate to them, a lot. It reminds you of where you were and that place you don't ever want to go back to. That's what I get out of my meetings.' Male, OCU, 42 (Duffy & Baldwin, 2013, p.5)

In Sannibale et al.'s (2003) study, for participants that attended at least one form of aftercare and for those who did not participate in any, the average point at which half of the participants were predicted to relapse was 209 days and 75 days respectively.

Relapse. Vanderplasschen et al. (2013) provide a systematic review of controlled studies of therapeutic communities that show relapse rates of 25 to 70%

within 12 to 18 months post-treatment and that 30 to 75% of the sample did not experience a relapse within the first-year post-treatment. Similarly, another systematic review of 61 therapeutic communities and 3271 participants shows relapse rates of 21 to 100% of individuals within the six-months to six-year timeframe post-treatment, and 20 to 33% had returned to a treatment facility (Malivert, Fatséas, Denis, Langlois, & Auriacombe, 2012).

A dysfunctional family is an issue often considered when assessing an individual and substance abuse (Santos Cruz & Felicissimo, 2017). Although restoring broken family relationships can be difficult, a positive family environment typically reduces the likelihood of relapse (Duffy & Baldwin, 2013; EnglandKennedy & Horton, 2011).

Moreover, research cautions that therapeutic communities are comparable to dysfunctional families in that they can become enablers of relapse (De Leon, 1995).

“Without affiliation with an authentic recovery community which supports and guides the use of aftercare services, the individual either avoids... [the] irrelevant system of caregivers, or reverts to manipulation of the system for immediate needs and gratification” (De Leon, 1995, p.1636). With the seriousness and complexity of high relapse rates, the literature review now turns to the changemakers who are leaders of social change in response to the substance abuse crisis.

Leadership and Social Change

In Brazil, therapeutic communities are predominately run by religious groups or former substance abusers (Ribeiro et al., 2013). The leadership of therapeutic communities is described as collective, often explaining the responsibilities of service providers or staff, and residents interchangeably (Tims, Jainchill, & De Leon, 1994).

Leaders of therapeutic communities play an important role in the systemic change being addressed; they make decisions regarding how their respective organization is going to function and the strategy for helping individuals on the recovery journey (Phillips & Fraizer, 2018). Consequently, the operational decisions the leaders make affect the success of a resident in maintaining sobriety (Phillips & Fraizer, 2018).

De Leon (1995) encourages service providers to guide residents as community members. Therapeutic communities should operate collectively in that the “teachers” and “therapists” are the community itself, deriving from the residents and service providers alike (De Leon, 1995). Service providers in therapeutic communities are typically a mix of former substance abusers and other traditional professionals, who often do not have professional credentials, nor are they required to have any credentials (Ribeiro et al., 2013), and “who must be integrated through cross-training” (De Leon, 1994, p.24). However, the Royal College of Psychiatry (2015) suggests service providers receive training as it relates to their work through continuing education at least two days per year, that training correlate to the core competencies of the respective therapeutic community, and that service providers are provided opportunities to participate in experiential training.

The function of each service provider is determined by the professional skills the individual possesses, such as nurse, lawyer, teacher, administrator, or counselor (IPEA, 2017). The Institute of Applied Economic Research (IPEA) (2017), a Brazilian government-led research organization, reported findings of their most recent survey of therapeutic community service providers, utilizing three classifications of occupations:

Group 1 – “doctors, nurses, psychologists, social workers, occupational therapists, physiotherapists, teachers, social educators” (p.28);

Group 2 – “monitors, coordinators, administrators, cleaning and maintenance workers, kitchen workers, and priests” (p.29); and

Group 3 – “agriculture & livestock workers, doormen or doorwomen, security guards”, (p.28).

The most common service provider from Group 1 is a psychologist followed by a social worker, and then teacher (IPEA, 2017). The survey also showed psychologists and social workers are the only two types of service providers that have a greater number of paid employees rather than volunteer-based service (IPEA, 2017). “Regardless of professional discipline or function, however, the generic *role* of all staff is that of community members who are rational authorities, facilitators, and guides” (De Leon, 1994, p.25). Furthermore, it is expected that residents themselves serve as role models to others within the organizational operations, including residents and directorial staff (De Leon, 1994). Based on De Leon’s framework, leadership characteristics are noted in the literature, however, particular theories implemented effectively by leaders are not yet defined. The collaborative nature and social impact of the therapeutic community model lends itself to certain leadership styles and theories, such as collective leadership and system leaders.

Collective leadership. Collective leadership is “a dynamic leadership process in which a defined leader, or set of leaders, selectively utilize skills and expertise within a network, effectively distributing elements of the leadership role as the situation or problem at hand requires” (Friedrich, Vessey, Schuelke, Rwark, & Mumford, 2009,

p.933). Key components of collective leadership are leader-team exchange, communication, a leader and team network, an affective team climate, and team performance parameters (Friedrich et al., 2009). Friedrich et al. (2009) posit specific conceptual skills that align with collective leadership: “intelligence, creativity, foresight, intuition, and wisdom” (p.947). Furthermore, interpersonal skills a collective leader embody are “network awareness, network accuracy, perspective taking, political skill, emotion regulation, and communication” (p.947). And, technical skills and capabilities “generally includes procedural knowledge related to the work the person does or to technical knowledge of how to be a leader” (p.947). There is a notable confluence between collective leadership and shared leadership, which “stresses the importance of sharing power among a set of individuals rather than centralizing it in the hands of a single superior” (Tal & Gordon, 2016, p.260). The literature demonstrates how in today’s increasingly complex systems, an organization’s leader “may not have all the skills needed to perform his or her functions effectively” (p.268) and collective leadership provides a solution to that challenge. Senge, Hamilton, and Kania (2015) expound upon collective leadership by demonstrating it as an element of a system leader.

System leaders. Arnold and Wade (2015) analyzed definitions of systems thinking and determined that it is “a set of synergistic analytic skills used to improve the capability of identifying and understanding systems, predicting their behaviors, and devising modifications to them in order to produce desired effects. These skills work together as a system” (p.675). System leaders use systems thinking to effectively lead their organizations. Furthermore, a system leader needs “to foster collective leadership” (Senge et al., 2015, p.28). Senge et al. (2015) provide three core capabilities for system

leaders: (a) to see the system at large, (b) to create a reflective environment and generate conversations that promote collective creativity, and (c) to shift “the collective focus from reactive problem solving to co-creating the future” (p.29). Trust and collaboration are products of effective system leaders (Senge et al., 2015).

Servant leadership. Another leadership style that therapeutic community leaders may identify with is servant leadership. “Servant-leaders empower and develop people; they show humility, are authentic, accept people for who they are, provide direction, and are stewards who work for the good of the whole” (van Dierendonck, 2011, p.1232). Robert Greenleaf (1977), servant leadership pioneer, articulated the following competencies and descriptions of corresponding traits for servant leaders:

1. Listening – Hearing and validating the viewpoints and perspectives of others,
2. Empathy – Demonstrating an understanding of what the follower is thinking and feeling,
3. Healing – Holistically caring for the well-being of followers,
4. Awareness – Consistently reflecting on one’s environment to envision the bigger picture,
5. Persuasion – Using clear communication to enact change in others,
6. Conceptualization – Aligning efforts to the long-term goals of the organization,
7. Foresight – Through analyzing past and present experiences, likely predictions for the future are made,
8. Stewardship – Utilizing the responsibility of the leadership position to the best of their ability for the good of society,

9. Growth of Others – Assisting in the personal and professional growth of others, and

10. Building Community – Nurturing the development of a community where individuals share values such as respect and connectedness.

Servant leaders typically embrace work that creates positive societal impact for the good of others (Northouse, 2013).

Social change. Leaders of one therapeutic community cannot solve Brazil's problem of substance abuse alone. However, with *collective impact* (Hanleybrown et al., 2012), individuals and organizations who share a common vision for solving the country's addiction problem could take effective measures to do so. Hanleybrown et al. (2012) posit specific conditions of collective impact, as opposed to *isolated impact*, to create social change: (a) a common agenda, (b) shared measures, (c) mutually reinforcing activities, (d) constant communication, and (e) backbone support (p.1). For a collective impact initiative to take place, "an influential champion (or small coalition), adequate financial resources, and a sense of urgency" (Hanleybrown et al., 2012, p.3) must be in place to work collectively among cross-sector organizations. A deeper understanding of the social impact of therapeutic communities and other addiction recovery efforts is needed (Kaplan & Broekaert, 2003).

Additional Considerations for Treatment

Madrugá et al. (2015) used the first Brazilian National Alcohol Survey data, which surveyed 3007 individuals, to conduct a cross-sectional study that shows meager rates of treatment engagement among the individuals with alcohol disorders. A subsample of 1590 alcohol users was selected, and 19.2% were identified as having alcohol abuse

and/or dependence. Almost 50% of individuals were not willing to stop drinking alcohol and less than 10% who abuse or were dependent on alcohol who were willing to stop also experienced prior treatment for their alcohol problem. In conclusion, treatment strategies should be more in sync with the individual's motivations to change. Thus, there is an urgent need for the implementation of alcohol interventions within primary care in Brazil, and their research may support its development (Madruga et al., 2015).

Some factors must be considered when assessing and implementing treatment. The following highlights several relevant areas leaders and managers should examine. Although recent efforts have been made to support drug reform in Brazil, the utilization of treatment is low (Cruz et al., 2014). Researchers took a closer look at young adult crack users in Rio de Janeiro who have been in- and out-of-treatment (Cruz et al., 2014). Results showed that:

Not-in-treatment users were less likely to: be white, educated, stably housed, be involved in drug dealing, report lifetime cannabis and current alcohol use, report low mental health status and general health or addictive/mental health care; they were more likely to: be involved in begging and utilize social services, compared to the in-treatment sample. (Cruz et al., 2014, p.1)

There is a need for available treatment services to be improved, including their access and delivery, with specific consideration given to the marginalized and high-risk substance users (Cruz et al., 2014).

Treatment centers should be prepared to address the complexities of the addicts with considerations made for their individual needs, such as comorbidities and addiction severity, and environmental factors, such as family support (Faller et al., 2014). The

leadership of drug abuse treatment organizations should take education, employment, and family relationships into consideration to better modify the treatment and enhance recovery (Faller et al., 2014; Marchi et al., 2017). Additionally, emphasis should be placed on identifying patient's family lifestyle "so that treatment can be tailored to specific aspects related to family structure, thus engaging family members in the treatment process and potentially improving outcomes" (Marchi et al., 2017, p.350).

One of the complexities in treatment lies in the diverse cultural backgrounds of individuals. Brazil is a diverse country with people living in a wide spectrum of cultural contexts. For example, as of 2010, there is a 1.1% Asian and .4% indigenous population in Brazil (CIA, 2018). These two groups of people come from significantly different cultural backgrounds and their social and cultural contexts should be considered in treatment. A case study conducted on an indigenous 20-year-old man who moved between São Paulo and his home village was dependent on crack-cocaine and cannabis and was seeking treatment (Mendonça et al., 2015). There is a lack of literature on understanding addiction within indigenous populations before implementing western ideals. Therefore, the case study researchers determined they would focus on this man's cultural background within the treatment plan (Mendonça et al., 2015). As part of the treatment, a shaman who was the man's grandfather performed a healing ritual in São Paulo that is part of the indigenous tradition (Mendonça et al., 2015). Three months later, abstinence was accomplished and the man eventually moved back to his home village (Mendonça et al., 2015). Mendonça et al. (2015) resolved that "a proper treatment plan must take cultural differences into account and should try to establish links between Western and traditional medicine" (p.266).

According to Pedrosa et al. (2016), an addict in treatment should not be identified as an addict but as “an individual capable of empowering actions” (p.904) and others should show their value of them as human beings by promoting social inclusion (Ribeiro et al., 2015). Occupational inclusion is fundamental in treatment, but it is common that addicts lack formal education or are incapable of maintaining a steady job due to the effects of drug use (Pedrosa et al., 2016). In the treatment of crack cocaine in Brazil, Pedrosa et al. (2016) determine that addicts should be patients of professionals in health, education, social assistance, and public security sectors. Professionals are encouraged to come up with a joint effort to help empower drug users to overcome their addictions, a system of support that lends itself to care management (Pedrosa et al., 2016; Pinsky et al., 2018).

The Brazilian government claims a desire to integrate the public health care system to better support substance addicts, but many proposed systems appear to only focus on acute and currently visible conditions rather than the chronic issues drug and alcohol abusers typically face (Pinsky et al., 2018). Pinsky et al. (2018) suggest the government adopt a care management model to alleviate the gaps in the current system, in particular, an organizing framework such as the Chronic Care Model (CCM), developed in the mid-90's. After a thorough review of scholarly work, the CCM may be the only academically grounded suggestion for integrating the system that appears in recent literature. Pinsky et al. (2018) believe the CCM's heavy emphasis on integration and coordination of care develops addicts' self-management skills and promotes high-quality management overall. Additionally, they agree this model is capable of functioning holistically well in the Brazilian social context. A variety of sound options are

available for implementation, however, changing the current system overall is quite the complex task.

Chapter 2 Summary

An examination of the academic and professional literature shows that the substance abuse situation in Brazil is complex and a challenging issue to South America's largest and influential country. The literature reviewed offers insight into the difficult reality faced by individuals and addiction recovery organizations. An important inference from the cited literature points to the uniqueness of Brazil's challenges in addressing substance abuse, a universal challenge. Seemingly effective research is nascent. However, more recent studies in the last five years show promising efforts and recommendations that may eventually prove to be seminal works in the future. To more fully understand the problem, future research should be conducted on relapse, and specific challenges addicts experience when transitioning out of recovery to reintegrate and live a meaningful, sober life. Repeatedly mentioned in literature, the current programs and organizations need to further assess and integrate their efforts to produce more effective results. And the question remains, how might therapeutic communities and other recovery options improve to better equip substance abusers in recovery to positively impact their odds at maintaining sobriety? Current efforts aid addicts in the transition from substance user to sobriety, however, the transition from sobriety in a recovery program to sobriety as an independent functioning individual living a purposeful life in society has little academic research available.

Chapter 3: Research Design and Methodology

Introduction

The intent of this chapter is to provide the plan that was utilized in this study to achieve its goal of generating findings of the lived experience of service providers working in therapeutic communities. This chapter restates the research questions that are addressed and expands on the phenomenological methodology used to conduct the study. The research design is outlined and addresses the population, sampling method, and criteria implemented. A section is designated to the International Review Board (IRB) to clarify human subject considerations. Furthermore, the technique and protocol used to interview participants are addressed in addition to demonstrating the validity and reliability of the research questions and corresponding interview questions. To conclude the chapter, the methods employed to analyze the data obtained from the study are discussed.

Re-Statement of Research Questions

This study focused on employing the following research questions to achieve the purpose of this research:

RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?

RQ2: What challenges are faced by therapeutic community service providers in their respective organizations?

RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?

RQ4: What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?

Nature of the Study

“Each research project holds its own integrity and establishes its own methods and procedures to facilitate the flow of the investigation and the collection of data” (Moustakas, 1994, p.104). The nature of this study is qualitative and used a transcendental phenomenological approach to obtain and describe findings for the research questions that have both personal significance to the principal investigator and social meaning and are listed above and proposed in Chapter 1 (Moustakas, 1994). Through semi-structured interviews, themes of the lived experience of therapeutic community service providers derived from the research questions.

Methodology

Aligning with Creswell’s (2007) definition of qualitative research, this study embarked with assumptions, the principal investigator’s worldview or set of beliefs, and a research problem exploring the lived experience of therapeutic community service providers in Brazil. Qualitative research directly includes the voice of the participant(s) (Creswell, 2007). Within this methodology, a framework exists to systematically proceed through the study, the research approach (Creswell, 2007). The framework determined to best meet the needs of this study is transcendental phenomenology.

Phenomenology, an approach to qualitative research design, comprehends the meaning, structure, and essence of individuals or groups lived experiences of a phenomenon (Creswell, 2007; Creswell, 2013; Patton, 2002). The focus of phenomenologists is to describe commonalities among all participants as they

experience a phenomenon with the intent to “reduce individual experiences with a phenomenon to a description of the universal essence” (Creswell, 2007, p.58). A phenomenon is not dictated by phenomenology rather phenomenology seeks to understand “how phenomena present themselves to consciousness” (Giorgi, 2012, p.6). One way a researcher may collect information for a phenomenological study is through unstructured or semi-structured and typically open-ended interviews and observations to obtain information from the participants (Creswell, 2014).

There are two types of phenomenology, hermeneutic phenomenology and empirical, transcendental phenomenology, of which the latter will be implemented. A primary difference between the two types of phenomenology is in how findings are generated (Lopez & Willis, 2004). Hermeneutic phenomenology is a “dynamic interplay among six research activities...[where]... phenomenology is not only a description but also an interpretive process in which the researcher makes an interpretation of the meaning of the lived experiences” (Creswell, Hanson, Clark, & Morales, 2007, p.253). However, transcendental phenomenology is less focused on the interpretation and instead concentrated on describing experiences and bracketing the investigator’s experiences as much as possible (Creswell et al., 2007). The study design is detailed in the following section and will provide additional specifics as to how transcendental phenomenology was applied to explore therapeutic communities.

Structured process of phenomenology. Many researchers have addressed process options for phenomenology such as Giorgi (1985) and Polkinghorne (1989). This study focused on the approaches proposed by Creswell (2007, 2014) and

Moustakas (1994). To conduct a disciplined phenomenological study, Moustakas (1994) suggests researchers include the following procedures in the study:

1. Discovering a topic and question rooted in autobiographical meanings and values, as well as involving social meanings and significance;
2. Conducting a comprehensive review of the professional and research literature;
3. Constructing a set of criteria to locate appropriate co-researchers;
4. Providing co-researchers with instructions on the nature and purpose of the investigation, and developing an agreement that includes obtaining informed consent, ensuring confidentiality, and delineating the responsibilities of the primary researcher and research participant, consistent with ethical principles of research;
5. Developing a set of questions or topics to guide the interview process;
6. Conducting and recording a lengthy person-to-person interview that focuses on a bracketed topic and question. A follow-up interview may also be needed;
7. Organizing and analyzing the data to facilitate development of individual textural and structural descriptions, a composite textural description, a composite structural description, and a synthesis of textural and structural meanings and essences. (p.103)

Appropriateness of phenomenology methodology. Edmondson and McManus (2007) suggest that examining methodological fit is one way to determine the appropriateness of a methodology. After reviewing the professional and academic literature on the topic presented in this study, it appears the phenomenon of the lived

experience of therapeutic community service providers as their work relates to addiction recovery resocialization is of nascent development, meaning little to no previous empirical studies exists. Edmondson and McManus advocate for phenomenology to be employed when collecting data from a nascent topic. Open-ended questions are used and appropriate “because little is known, rich, detailed, and evocative data are needed to shed light on the phenomenon” (Edmondson & McManus, 2007, p.1162).

Additionally, transcendental phenomenology, pioneered by Edmund Husserl and more currently advocated for by Clark Moustakas, is an appropriate approach for this study as the principal investigator is searching to elicit understanding of the human experience (Moerer-Urdahl & Creswell, 2004; Moustakas, 1994). A *transcendental* approach is utilized when researchers desire a fresh perspective as if the knowledge and understanding were being exposed for the very first time, hence the reason for bracketing, explored later in this chapter. Moustakas upholds the idea that what the world sees is gained by learning, however, what consciousness sees is an absolute reality (1994). The transcendental approach is systematic and creates balance by integrating experience and behavior using experiences from each participant in the study (Moerer-Urdahl & Creswell, 2004; Moustakas, 1994).

Strengths. According to Edmondson and McManus (2007), the best methodological fit for a nascent topic is either a qualitative-only study or a hybrid of qualitative and quantitative methodologies. Additionally, after conducting a study intended to explore Moustakas’ transcendental phenomenology procedures, Moerer-Urdahl and Creswell (2004) determined the following strengths of this methodology:

- It allows researchers to cultivate “an objective ‘essence’ through aggregating subjective experiences of a number of individuals” (p.23);
- The approach is suitable when the research is seeking to understand an identified phenomenon and participants are accessible to describe their experience with the phenomenon;
- The framework’s interview process is efficient;
- The approach is consistent with human science research since it entails collecting data from participants who personally experienced the phenomenon seeking to be better understood.

Weaknesses. Moerer-Urdahl and Creswell (2004) note that since experiences vary greatly due to each participants’ background and culture, it is difficult to develop the essence when interviewing a heterogeneous unit even when they have the phenomenon in common. Additionally, phenomenology requires researchers to bracket personal experiences which may be difficult to achieve (Creswell, 2007; Moerer-Urdahl & Creswell, 2004). Finally, nascent qualitative research tends to fall outside guidelines for a statistical inference which may cause quantitative methodologists to be unconvinced of its value (Edmondson & McManus, 2007).

Research Design

A proper research design is cautious to maintain consistency and provide a clear explanation of the approach used to answer the research questions (Meadows & Morse, 2001). Thus, the plan for this study included clarity regarding the analysis unit, population, sample size, and the inclusion and exclusion criteria that was applied to elicit responses for the research questions that were guided by a review of the literature.

Analysis unit. Creswell describes how a unit of analysis varies depending on the approach taken to conduct the research (2007). In a phenomenological study, a unit of analysis studies “several individuals that have shared the experience” (Creswell, 2007, p.78). The single unit of analysis in this study is a therapeutic community service provider whose organization is affiliated with FEBRACT or SDSTJDH in Brazil. Service providers support the recovery of the individuals residing in the organizations for which they are employed.

Population. Qualitative studies address specific populations when theories have yet to be developed, are inadequate, or partially developed (Creswell, 2007). In Brazil, the quality and quantity of therapeutic communities are unknown, although therapeutic communities are one of the primary recovery options for addicts seeking treatment (Gómez-Restrepo et al., 2018). Given the significance of the role therapeutic communities play in addiction recovery, few studies have been conducted. The population for this study derived from therapeutic community service providers of organizations affiliated nationally with FEBRACT or with SDSTJDH in the state of Rio Grande do Sul. A total of 136 organizations throughout Brazil comprised the population of this study.

Sample size. When deciding the sample size of a population in a qualitative study, Morse (2000) suggests several factors be considered: the scope of the study, the nature of the subject, the quality of the data, the study design, and how participants discuss the experiences of others. The nature of a phenomenological study requires extensive study of a small sample (Dukes, 1984). Pertaining specifically to phenomenological studies, a researcher may gather data from a range of participants,

from 1 (Dukes, 1984), 5 to 6, (Morris, 1995) 6 to 10 (Morse, 2000), or 5 to 25 (Polkinghorne, 1989). Thus, this study aimed to utilize a sample size of 15 participants.

Purposive sampling. There are a variety of purposeful sampling strategies available to qualitative researchers that aid the process of identifying study participants who have each experienced the phenomenon studied (Creswell, 2007). After determining the population and sample size of a phenomenological study, a sampling strategy is identified. Creswell (2007) describes various strategies that could be used to identify the best participants for the study, common types of sampling include: maximum variation, critical cases, convenience cases, and criterion. The purposive sampling strategy implemented in this study is maximum variation.

Participation selection: Sampling frame to create master list. The principal investigator obtained the participation selection of therapeutic community service providers to advance the understanding of the phenomenon studied through a four-part process. The steps for each part are outlined below with specific measures that were taken to obtain the participant selection. The principal investigator created a master list in a password protected Microsoft Excel spreadsheet of the therapeutic communities and the corresponding contact information for each organization listed. Each potential participant acquired information on the study and were recruited by the investigator via email. A Microsoft Word document of the recruitment letter was stored on the principal investigator's password protected personal computer and emailed to each potential participant. The following describes the steps taken to identify the master list of prospective participants:

1. Obtain a list of therapeutic communities affiliated with FEBRACT in Brazil.
 - *Step One:* On a web browser, visit the publicly accessible website:
<http://febract.org.br/portal/filiadas>.
 - *Step Two:* On the resulting page, an image of the country of Brazil will show each state, including the federal district of Brasilia, outlined and labeled with its corresponding state abbreviation. Click on the state labeled “RS”.
 - *Step Three:* Exclude therapeutic communities that specifically denote that the organization is for females only, displayed as "Feminina".
 - *Step Four:* As of February 12, 2019, the resulting list yields publicly accessible contact information for 32 therapeutic communities in the state of Rio Grande do Sul (RS).
 - *Step Five:* Repeat steps 1-3, for the remaining states, selecting a different state labeled in Step Two.
 - *Step Six:* As of February 12, 2019, the resulting list yields publicly accessible contact information for an additional 100 therapeutic communities in the states of São Paulo (SP - 73), Santa Catarina (SC - 4), Paraná (PR - 6), Rio de Janeiro (RJ - 1), Minas Gerais (MS – 1), Goiás (GO – 4), Espírito Santo (ES – 1), Distrito Federal (DF – 1), Bahia (BA – 3), Ceará (CE – 2), Maranhão (MA – 1), Pará (PA – 1), Acre (AC – 1), and Rondônia (RO – 1). The complete list yields publicly accessible contact information for a total of 132 therapeutic communities affiliated with FEBRACT.

2. Obtain a list of therapeutic communities affiliated with SDSTJDH in Rio Grande do Sul.
 - *Step One:* On a web browser, visit the publicly accessible website: <http://www.sdstjdh.rs.gov.br/comunidades-terapeuticas>.
 - *Step Two:* On the resulting page, a list of the therapeutic communities registered with the “SDSTJDH” will appear to the left of the map.
 - *Step Three:* Exclude therapeutic communities that specifically denote that the organization is for females only, displayed as "Feminina".
 - As of August 15, 2018, the resulting list yields publicly accessible contact information for 50 therapeutic communities in the state of Rio Grande do Sul (RS).
3. Apply inclusion and exclusion criteria, as described in the sections below. In the Microsoft Excel spreadsheet, the principal investigator added columns denoting specific inclusion criteria required for prospective participants to meet. At any point a prospective participant did not meet the criteria, the organization will be eliminated from the sample.
4. Apply criteria for maximum variation, as described in the sections below.

Criteria for inclusion. Each participant in this study must at a minimum have met the following inclusion criteria:

- Participants must be a current service provider of a therapeutic community in Brazil.
- Participants must speak English.
- Participants must be at least 19 years old or older.

Criteria for exclusion. Furthermore, the following criteria for exclusion was included:

- Any participant who is unwilling to be audio recorded for the interview (Moustakas, 1994).
- Participant's organization does not work with male substance abusers.
- Any participant who is unavailable to participate in a virtual or face to face interview prior to March 22, 2019.
- Any participant who is unwilling to sign informed consent participation in the study.

Purposive sampling maximum variation. Finally, to ensure the study sample was representative of various therapeutic communities, a maximum variation technique, when possible, was applied. The process of maximum variation ensures diversity and allows the principal investigator to identify common themes relevant to the phenomenon studied (Creswell, 2007). Maximum variation is a familiar approach used in qualitative studies to determine in advance the specific criteria that set apart participants (Anderson, 2017; Andrews, 2016); and then selects participants that increase “the likelihood that the findings will reflect differences or different perspectives” (Creswell, 2007, p.126). Geographic location is the criteria for maximum variation applied to this purposive sample; to include participants of therapeutic communities in both Rio Grande do Sul and São Paulo.

Human Subjects Consideration

Before conducting research on humans, permission must be obtained from a human subject review board (Creswell, 2007). This research is guided by ethical

principles, by Title 45, Part 46 of the U.S. Code of Federal Regulations, Pepperdine University's Internal Review Board (IRB). A proposal was submitted to the IRB that detailed the procedures that were to be implemented for this research. Following the IRB's approval, the data collection commenced.

Confidentiality disclosure. This study protects the anonymity of individuals involved and maintains confidentiality by taking precautions employing several safeguards. The electronic data collected secures participants' information with password-protected access, and the data will be de-identified by the principal investigator. Hardcopy data is stored in a locked office in a locked file cabinet with data de-identified by the principal investigator. Both electronic and hardcopy data was coded with a master list secured and stored separately.

Risk minimization. All research creates some form of potential risk for the participants involved in a study, although the degree of distress placed on the individual varies (Corbin & Morse, 2003). For those who participated in this study, a potential risk may have included fatigue from the duration of the interview and discomfort regarding the questions asked during the interview (Reynaldo, 2017). To minimize the potential risk, participants were reminded by the principal investigator of their option to terminate further involvement in the study and that their time is purely voluntary (Reynaldo, 2017). Each participant was informed of potential risks involved in the study through an informed consent form, and each participant provided a signed copy of the form to demonstrate that the amount of risk involved was acceptable. This study did not involve a vulnerable population, and the data that was collected is stored on a password-protected computer as outlined in the next section.

Data confidentiality and storage protocol. All digital recordings and transcriptions are stored on the principal investigator's password-protected personal computer. Included in these documents, is the password protected Microsoft Excel spreadsheet of the master sample list. Also, the interviews were recorded using a password protected iPhone recording device and then transferred to audio files saved on the computer and transcribed into a password protected Microsoft Word document, saved as a password protected PDF document as well. Once interview recordings were transcribed, the recordings were destroyed via hard drive permanent deletion. The electronic transcriptions and all other written and audio information the participants provided are stored with password-protected access on the principal investigator's personal computer for a maximum of three years. No documents nor recordings are stored in the cloud. Furthermore, safeguards were applied in reporting the data collected by the use of pseudonyms (i.e. P1-P15) and not conveying recognizable information about the participant or organization with which they are associated (Creswell, 2007).

Expected benefits of participation. "When research is conducted with sensitivity and guided by ethics, it becomes a process with benefits to both the participants and researchers" (Corbin & Morse, 2003, p.335). One of the primary benefits is that the results of this study directly contribute to the specific knowledge and experience of service providers in therapeutic communities implementing strategies to aid addicts in the recovery process. Secondly, the results of the study contribute to the nascent literature relating to therapeutic communities and addiction recovery. Furthermore, each participant received a copy of the findings. "Rewards and

appreciation can provide respect and reciprocity for those who provide value data in a study” (Creswell, 2014, p.98). No monetary reward was offered or given for participation in the study.

Voluntary statement. Participation in this study was voluntary for all participants. A participant wishing to withdraw from the study at any point in time was able to do so, and involvement with the study would have been terminated immediately. Individuals were not penalized if at any point in time they refused to continue participating.

Informed consent. According to the Protection of Human Participants in Research policy and procedures manual (2009), the process for informed consent, according to federal guidelines, requires three elements. The first element is full disclosure of the nature of the research and the role the participant will play which involves eight components: “(a) description of the research (purpose, duration, procedures); (b) risks; (c) benefits; (d) alternatives; (e) confidentiality; (f) compensation for injury; (g) whom to contact; and (h) right to withdraw or refuse” (p.46). Second, an adequate understanding on the part of the prospective participants is required. Lastly, the participant’s voluntary choice to be a part of the study is included. Outlined below are the specific steps used to communicate with the prospective participants after the master list was obtained. This process complied with the federal regulations and met federal and California state regulations (Protection of Human Participants in Research: Policies and Procedures Manual, 2009).

- **Step 1A** – Email therapeutic communities from the master list with the standardized recruitment letter (see Appendix A). The initial email introduces the

principal investigator, provides a description of the objective of the study, and gauges interest from prospective service providers.

- **Step 1B** – Three days after sending the initial recruitment emails, an initial follow-up email (see Appendix B) will be sent to prospective participants who have not responded to confirm receipt of the email.
- **Step 1C** – Send subsequent follow-up emails to unresponsive prospective participants one additional time, three days following the initial follow-up email and every three days after that until sample size is reached.
- **Step 2A** – For those who confirmed interest, send an email with prospective interview dates and a request for confirmation of willingness to participate in the study, written confirmation or a signed copy of the informed consent form (see Appendix C), and the best form of communication for the future contact. The following documents will be included as attachments to this email: (a) a copy of the informed consent form and (b) a list of the four research questions and eleven corresponding interview questions.
- **Step 2B** – Three days after sending the email to individuals who confirmed interest, send a follow-up email to those who have not responded.
- **Step 3** – For those who have provided written confirmation in an email or emailed a signed a copy of the informed consent form, confirm the time and place for the 45 to 60-minute interview with each prospective participant meeting the criteria.
- **Step 4** – Once confirmation of the time and place for the interview is received, each participant will receive a calendar notification.

- **Step 5** – The weekday before each of the designated interviews, send a reminder email of the agreed upon time and location with an attached list of the interview questions.

Data Collection

Semi-structured interviews were conducted for approximately 45 to 60-minutes. The following section outlines interview techniques as part of data collection. Traditionally, data collection in phenomenological studies is obtained from multiple individuals who have all experienced the phenomenon being researched (Creswell, 2007).

Interview techniques. An interview process form (see Appendix D) designed and printed before each interview is a tool used by principal investigators to record information collected during interviews (Creswell, 2007). The form allows the principal investigator to take organized handwritten notes during the interview. In this study, interviews were conducted in-person or via telephone. In addition to audio recording the interview, the principal investigator used a readily available interview process form to take notes. The detailed in-person or telephone interviews were conducted at a mutually agreeable location and time for both the participants and principal investigator (Moerer-Urdahl & Creswell, 2004).

For in-person interviews, the principal investigator arrived at the agreed upon location, prepared to begin the interview at the agreed upon time. The conversation started with a proper greeting and the participant provided a hard copy of the interview questions. Then, an explanation of what to expect during the interview, a review of the purpose of the study, and reminder that the interview will be recorded was

communicated. Participants were asked if they have any additional questions before the interview officially began. After all questions were answered, the principal investigator informed the participant that the audio recording was starting.

For the telephone interview, the principal investigator called the participant at the scheduled agreed upon time. The conversation started with a proper greeting and the participant was reminded of the list of interview questions they received the previous day via email. Then, the principal investigator provided an explanation of what to expect during the interview, reviewed the purpose of the study, and reminded the participant that the interview will be recorded. The participant had any additional questions answered before the interview officially began. After all questions were resolved, the principal investigator informed the participant that the audio recording is starting.

Throughout both in-person and telephone interviews, while asking the interview questions, time was allowed for the participant to adequately reflect and respond. Follow-up questions may have been asked to clarify responses in order to better comprehend the experiences being shared (Creswell, 2007). The principal investigator concluded the interview and expressed appreciation for the service provider's time, thoughtfulness, and openness to participating in the study. The principal investigator concluded the interview by asking if the participant was open to answer any follow-up questions that may develop (Creswell, 2007).

Interview Protocol

The protocol, "an instrument for collecting data" (Creswell, 2007, p.7), was employed through interview questions. The relationship between each of the research questions and the initial interview questions will be discussed in the following section.

The final interview questions for the protocol resulted from the outlined process that provides validity to the instrument. To conclude, specific components that ensure the reliability of the instrument are addressed.

Relationship between research and interview questions. Eleven interview questions that correspond with the four research questions were determined by the principal investigator after being informed by the current literature, addressed in Chapter 2. The primary areas of literature reviewed regard the present drug situation in Brazil, therapeutic communities, and other efforts within the country to combat the severe addiction issue. Appendix E provides a table demonstrating the relationship between the research questions and the original interview questions.

Interview questions. In order to gather data for this research study, the following eleven interview questions were used (see Table 1):

IQ 1: What business strategies and/or practices have helped you be successful in your organization?

IQ 2: What leadership practices and/or techniques have helped you be successful as a therapeutic community service provider?

IQ 3: What education/training or work experiences prepared you in your role as a therapeutic community service provider?

IQ 4: What personal characteristics prepared you in your role as a therapeutic community service provider?

IQ 5: What challenges have you faced in leading therapeutic community services within and outside your organization?

IQ 6: How did you overcome these challenges?

IQ 7: How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?

IQ 8: How do you define and measure your success as a therapeutic community service provider?

IQ 9: What advice or recommendations would you give to therapeutic community service providers?

IQ 10: What advice or recommendations would you give to therapeutic community organizations?

IQ11: Is there anything else you would like to add?

Validity and reliability of the study. Validity is an outcome goal of this research study. Validity was “achieved through the process of demonstrating trustworthiness, which in turn addresses both reliability and validity” (Meadows & Morse, 2001, p. 196). Reliability implies that the study can be replicated and that the findings found in replication will be similar to those found in the study (Meadows & Morse, 2001). A four-pronged approach was implemented in this study to ensure the validity and reliability. The first step of the validity and reliability approach is prima-facie validity, followed by peer-review validity and then expert-review validity, and completed with the reliability of the instrument (Creswell, 2007).

Prima-facie validity. The principal investigator created interview questions, informed by the literature, and that aligned with each of the corresponding research questions. This study has 11 interview questions that focus on understanding the phenomenon being researched. Prima-facie validity was achieved by determining clear

questions that allowed the data collected to be measured against the purpose of the study.

Peer-review validity. The next step of the validation strategy was to have a peer review of the research questions and corresponding interview questions. To obtain honest feedback from peers that would probe at the proposed questions, the principal investigator recruited two practitioners to be peer reviewers (Creswell, 2007)—who have extensive work experience and/or knowledge in the general topic and/or methodology. Each peer reviewer was sent an email (see Appendix F), which provided instructions and an evaluation form outlining the research questions and interview questions (see Appendix G). The principal investigator requested each peer reviewer evaluate the interview questions individually in the following manner:

- Mark “Keep as stated,” if the interview question appropriately addresses its corresponding research question.
- Mark “Delete question,” if the interview question is irrelevant to the corresponding research question.
- Mark “Suggested modifications,” if the interview question could be modified to better fit the corresponding research question.

After a thorough analysis of the questions was completed, the peer reviewers were asked to email their typed responses to the principal investigator. The results from the feedback are explained below and the research questions with their respective revised interview questions are provided in Table 1.

- Related to RQ 1, for more relevancy and effective language, interview questions 2 and 3 were modified as follows:

- IQ 2: Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider.
- IQ 3: Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider.
- Related to RQ 4, for more relevancy, interview question 9 was modified as follows:
 - IQ 9: What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community?

Expert-review validity. The third step in this study's validation strategy is that of expert-review. Since consensus was reached after the peer-review process was completed, an expert review is not needed. However, if consensus had not been reached, the Committee would have served as expert reviewers to determine the appropriate action to be taken. Therefore, Table 1 serves as the final edition of the research questions and corresponding interview questions.

Table 1

Research Questions and Corresponding Interview Questions (Final)

Research Questions	Corresponding Interview Questions
RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?	<p>IQ 1: What business strategies and/or practices have helped you be successful in your organization?</p> <p>IQ 2: Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider.</p> <p>IQ 3: Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider.</p> <p>IQ 4: What personal characteristics prepared you in your role as a therapeutic community service provider?</p>
RQ 2: What challenges are faced by therapeutic community service providers in their respective organizations?	<p>IQ 5: What challenges have you faced in leading therapeutic community services within and outside your organization?</p> <p>IQ 6: How did you overcome these challenges?</p>
RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?	<p>IQ 7: How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?</p> <p>IQ 8: How do you define and measure your success as a therapeutic community service provider?</p>
RQ4: What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?	<p>IQ 9: What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community?</p> <p>IQ 10: What advice or recommendations would you give to therapeutic community organizations?</p> <p>IQ 11: Is there anything else you would like to add?</p>

Note. The table identifies four research questions and corresponding interview questions that have been peer-reviewed.

Instrument reliability. The final step of the validity and reliability approach for this study is instrument reliability. The reliability of a qualitative instrument suggests an instrument is consistent and capable of being accurately used by different researchers and different studies (Creswell, 2014; Gibbs, 2007). The following components were implemented in this study to ensure reliability:

- *Record keeping.* The principal investigator's password protected personal computer is used to store all electronic data including signed informed consent forms, a password protected Microsoft Word document of the interview transcriptions, and a password protected Microsoft Excel spreadsheet of the sample list.
- *Pilot session.* To ensure the reliability of the interview protocol, one pilot interview was conducted with an individual who meets the criteria of the study. This pilot interview assists the principal investigator in assuring that a sufficient number of interview questions can be answered within the 60-minute timeframe (Darnell, 2018; Reynaldo, 2017). After the pilot session was conducted, the principal investigator determined that no changes are needed to the interview protocol.
- *Review frequency.* After the interviews were conducted and all data was collected and transcribed, the principal investigator reviewed each recording at least two times to ensure the accuracy of the transcription.

Data Analysis

The process of data analysis for psychological phenomenologists, such as Moustakas and Giorgi, contain similar methodological qualities (Creswell, 2007; Giorgi,

2012). Data analysts review the data collected from the interview transcriptions and other forms of data, if applicable; determine the statements, words, or quotes that are significant in understanding the phenomenon; and eventually develop clusters of meanings that derive from the significant data (Creswell, 2007). This study employed the systematic method outlined by Moustakas (1994): (a) epoche, (b) transcendental phenomenological reduction, (c) imaginative variation, and (d) synthesis.

Epoche. The data analysis of this transcendental phenomenological study began with the challenging process of seeking to see the data as it appears, known as epoche (Moustakas, 1994). *Epoche* means to abstain from judgment (Moustakas 1994; Patton, 2002). A researcher must be able to “*look before judging*” (Patton, 2002, p.485) and bracket out all external presuppositions to allow the information to be received “in pure form, uncontaminated by extraneous intrusions” (p.485). Researchers set aside their biases by reflecting on their experiences and clearing their mind of those experiences to be prepared for an authentic meeting with the study’s participant (Moustakas, 1994).

Statement of personal bias. Aligning with the principles of epoche, the principal investigator will now provide insight to the reader regarding past experiences and how they have likely shaped this study and its approach (Creswell, 2007). Furthermore, it is important for the principal investigator to be conscious of her personal biases and values, and the experiences that have shaped the biases through repeated reflective-meditation (Creswell, 2007; Moustakas, 1994). Therefore, the following statements present personal bias:

I pursued this research study as a result of my current leadership role in developing a halfway house to receive men transitioning out of rural therapeutic communities in southern Brazil. Additionally, I have had exposure to several therapeutic communities before and during this study, therefore, impacting my perspective on how therapeutic communities operate. Moreover, I moved to southern Brazil from the United States in January 2018, having traveled to the country for annual short-term trips since 2013. I hold a Bachelor's degree in Spanish, a Master's degree in Organizational Leadership, and I am 29 years of age. Between my work and educational experience, I take a personal interest in the lived experience of therapeutic community service providers.

Transcendental phenomenological reduction. Following epoche, the first dimension of the data analysis process, the study moved forward into transcendental phenomenological reduction. A transcendental phenomenological reduction can be approached in a number of ways, providing a fresh perspective about the phenomenon being studied (Schmitt, 1959). The following four steps summarize the process of phenomenological reduction:

1. Bracketing: In order to set aside everything but the research phenomenon and questions being researched, the principal investigator must bracket the objective world (Moustakas, 1994; Schmitt, 1959);
2. Horizontalizing: Each piece of data collected from the interviews is treated as having equal value. This step is where specific statements and words are identified and separated from irrelevant, repetitive, or overlapping data (Moerer-Urdahl & Creswell, 2004; Moustakas 1994). The statements and

words identified are called the *horizons*, “the textural meanings and invariant constituents of the phenomenon” (Moustakas, 1994, p. 94).

3. Clustering: The horizons are then clustered into themes (Moustakas, 1994);
4. Organizing: The themes are arranged into a coherent textural description of the phenomenon in the final step of transcendental phenomenological reduction (Moustakas, 1994).

According to Husserl, following this step is where phenomenology can begin (Schmitt, 1959).

Review of transcription considerations. Before determining the *horizons*, the interview recordings were listened to at a minimum of two times to ensure precision of the transcription. The participants were then invited to review the final version of the transcript of their recorded interview. Participants provided suggested edits, if applicable, and then agreed to the final transcription. All edits made by the participants were included in the final transcription used in data analysis.

Inter-rater reliability and validity. An iterative process is taken throughout this study to verify the validity and reliability of the research (Morse et al., 2002). Within the third step of transcendental phenomenological reduction, an additional layer of reliability and validity was employed by way of utilizing a committee of peer reviewers to assist in coding the data. The peer review committee comprised of two doctoral level students with training in qualitative research. After the principal investigator identified the horizons and clusters the horizons from the first three interviews into themes, the peer reviewers provided feedback, suggestions and disagreements, regarding the initial coding. Since consensus between the principal investigator and two peer reviewers was

reached, the principal investigator employed the agreed-upon coding approach to the remaining interviews. In the event consensus had not been met between the principal investigator and peer reviewers, the dissertation committee would have assisted in determining the direction of the coding approach.

Other coders. Since the reliability of a qualitative study typically derives from “the stability of responses to multiple coders of data sets,” (Creswell, 2007, p.210) additional individuals’ input was sought. This additional layer of reliability was obtained from individuals with significant professional expertise with the purpose of this study. A table demonstrating how the horizons were clustered was constructed and provided to the experts by the principal investigator. Once consensus was reached by the experts, the principal investigator moved forward by organizing and describing the themes.

Software coding considerations. A variety of software programs exist to assist researchers with coding data, of which Creswell (2007) highlights the most common: NVivo, Maxqda, Atlas.ti, and HyperRESEARCH. Essentially all qualitative software programs provide similar features and other researchers may assist in determining which program will meet the needs of a study if any (Creswell, 2007). However, validation of the coding process is deemed to be more appropriately conducted by the principal investigator and two peer auditors (Darnell, 2018; Fraizer, 2009).

Increase reliability of information and considerations. The following sections summarizes the considerations that were taken to ensure the data is both reliable and accurate:

1. **Imaginative variation.** The primary task in the imaginative variation step is to describe the fundamental structures of the phenomenon being researched

given the individual themes have now been organized (Moustakas, 1994). By way of the phenomenological reduction process the textural descriptions are acquired and the researcher is then empowered to develop structural themes (Moustakas, 1994). Moustakas (1994) describes the phases of imaginative variation as follows:

- Systematic varying of the possible structural meanings that underlie the textural meanings;
- Recognizing the underlying themes or contexts that account for the emergence of the phenomenon;
- Considering the universal structures that precipitate feelings and thoughts with reference to the phenomenon, such as the structure of time, space, bodily concerns, materiality, causality, relation to self, or relation to others;
- Searching for exemplifications that vividly illustrate the invariant structural themes and facilitate the development of a structural description of the phenomenon. (p.96)

2. **Synthesis.** Synthesizing the descriptions, both textural and structural, concludes Moustakas' (1994) steps in the phenomenological research process. The purpose of synthesis is to determine the meanings and essence and ultimately to synthesize the experiences into an integrated description of the phenomenon (Moerer-Urdahl & Creswell, 2004; Moustakas, 1994). Through epoche, phenomenological reduction, imaginative variation, and

synthesis, a phenomenological study may be conducted to learn about the human experience (Moustakas, 1994).

Chapter 3 Summary

Chapter three opens with a discussion on qualitative methodology and transcendental phenomenology, that was employed in this study. The research design follows, outlining the analysis unit, population, sampling frame, and inclusion and exclusion criteria of this study. Then, to protect the human subjects who will be interviewed, protective measures are outlined and were approved by Pepperdine University's IRB. Next, the technique to determine the final interview questions is outlined. Finally, chapter three ends by extensively examining how Moustakas' research process is reflected and provides iterative layers of validity and reliability to the data analysis.

Chapter 4: Findings

The purpose of this study was to understand and determine the strategies and practices, challenges, and measures of success current service providers employ and recommend when leading residents through addiction recovery in therapeutic communities. Answers to the following four research questions were obtained to realize the purpose of this study:

RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?

RQ2: What challenges are faced by therapeutic community service providers in their respective organizations?

RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?

RQ4: What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?

The principal investigator developed an interview protocol including 11 open-ended interview questions to answer the four research questions. In order to confirm the validity and reliability of the 11 interview questions, a four-pronged approach was implemented: prima-facie, peer-review, expert-review, and reliability of the instrument (Creswell, 2007). The expert-review was not needed due to the consensus reached between the principal investigator and two peer-reviewers regarding changes made to the instrument. The validity process resulted in the following 11 interview questions:

1. What business strategies and/or practices helped you be successful in your organization?

2. Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider.
3. Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider.
4. What personal characteristics prepared you in your role as a therapeutic community service provider?
5. What challenges have you faced in leading therapeutic community services within and outside your organization?
6. How did you overcome these challenges?
7. How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?
8. How do you define and measure your success as a therapeutic community service provider?
9. What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community?
10. What advice or recommendations would you give to therapeutic community organizations?
11. Is there anything else you would like to add?

After the peer-review, instrument reliability was ensured through recordkeeping, a pilot interview, and multiple reviews of interview transcripts. Interview participants of this study were asked to respond openly to the 11 interview questions and provide a detailed response, to the extent at which they deemed appropriate. This chapter describes the participant for this study, reports on the data collection process, data

analysis process, and inter-rater review process. Most importantly, this chapter provides the findings collected from the analysis of the data obtained from the five participants' responses to the 11 interview questions.

Participants

For this study, the principal investigator interviewed five individuals who were current service providers in therapeutic communities. Two participants were male and three were female. All participants worked at therapeutic communities currently affiliated with FEBRACT. Two of the participants were co-founders and are currently Directors at their respective therapeutic community, the other three participants are a Psychologist, a Nurse, and a Human Resources Manager.

Participant 1. Participant 1 is a former President of her therapeutic community's board and describes her current position as a Human Resources Manager. She has been a service provider in her therapeutic community since 2007. Her therapeutic community is located in the state of São Paulo and receives men between the ages of 18 and 60 years old. The interview with Participant 1 was conducted onsite in Participant 1's office. After the interview, Participant 1 gave the principal investigator a tour of the facilities.

Participant 2. In 2009, Participant 2 co-founded his therapeutic community in São Paulo state. Currently, Participant 2 serves as the Director of his therapeutic community that receives 18 to 65-year-old men, presently with 40 residents and a capacity of 50. The principal investigator was introduced to several of the other service providers on staff and given a tour of the facilities.

Participant 3. Participant 3 is the only psychologist on staff at her therapeutic community in São Paulo state. Participant 3 has eight years of experience working in therapeutic communities and five of those with the current community, both located in São Paulo state. The therapeutic community has 28 of the 30 available spots filled. The interview was conducted at the therapeutic community's newly acquired house that is in the process of being renovated into a república. Before the interview took place, Participant 3 and her colleague, one of the three coordinators at the therapeutic community, showed the principal investigator the house and excitedly shared plans for what they desire for the república.

Participant 4. In 2007, Participant 4, his wife, and the local Catholic priest founded the therapeutic community. Participant 4 describes his current position as Director. The facility has a capacity of 72 and currently has 63 male residents ages 18 to 60 years old. Participant 4 estimated the average resident is 30 years old. After the interview at the therapeutic community in São Paulo state, Participant 4 introduced the principal investigator to all of the present staff members and provided a tour of the facilities.

Participant 5. Participant 5 has been working at her therapeutic community located in Rio Grande do Sul for the past five years. Participant 5 is the nurse overseeing all four of the therapeutic community's locations. Combined, the locations have a capacity 160, offering services to males and females. Accepting individuals of all ages, Participant 5's community currently has residents ranging from 15 to 72 years old. Participant 5's husband is the psychologist for the therapeutic community.

Data Collection

After obtaining full IRB approval (Appendix H) in December 2018 from Pepperdine University, an initial master list of prospective participants in the states of São Paulo and Rio Grande do Sul was obtained from the FEBRACT and SDSTJDH publicly accessible websites, <http://febract.org.br/portal/filiadas> and <http://www.sdstjdh.rs.gov.br/comunidades-terapeuticas>, respectively. Next, the list was filtered to identify therapeutic communities with publicly provided emails and to exclude organizations that specifically denote that the organization is for females only, displayed as “Feminina”. The remaining criteria for inclusion and exclusion were determined during correspondence with the prospective participants. Data collection began January 2, 2019 utilizing the recruitment script (Appendix A) the IRB approved.

In January, recruitment letters were sent via email to the prospective participants affiliated with FEBRACT in São Paulo and Rio Grande do Sul and SDSTJDH in Rio Grande do Sul. The initial round of recruitment letters sent totaled 114. Due to the low response rate, mid-February, the principal investigator determined it was an appropriate time to expand the population of the study to include therapeutic community service providers of organizations affiliated with FEBRACT throughout all of Brazil. An amendment to the original IRB proposal to expand the study was submitted and approved (Appendix H). After obtaining IRB approval to include the additional 12 Brazilian states with therapeutic communities affiliated with FEBRACT, the principal investigator added the additional prospective participants with publicly accessible emails to the master list, excluding organizations that specifically denote that the organization

is for females only, displayed as “Feminina”. Expanding the population of the study yielded 22 additional prospective participants.

After expanding the population, a total of 136 prospective participants were contacted. When possible, maximum variation was applied. The recruitment process yielded a total of five interviews from participants affiliated with FEBRACT in São Paulo and Rio Grande do Sul. Additional responses were received from recruitment emails that did not result in interviews: 11 responses from organizations informing they do not have an English speaker, one prospective participant who declined participation after learning more about the study, and three prospective participants who expressed interest but did not follow-up with the principal investigator to schedule an interview. The recruitment process and interviews were conducted through March 1, 2019.

Table 2

Prospective Participants Response

	FEBRACT São Paulo	FEBRACT Rio Grande do Sul	SDSTJDH Rio Grande do Sul	FEBRACT Other
No response	49	23	12	19
Undeliverable email	7	3	1	2
Responded, no English speaker	8	3	0	0
Responded, no follow-up	1	1	0	1
Responded, declined participation	1	0	0	0
Interviewed	4	1	0	0
Total Prospective Participants	70	31	13	22

Before the interview, the five participants who agreed to be interviewed were each provided a copy of the informed consent form, a description of the purpose of the study, and a copy of the 11 interview questions. Each participant signed a copy of the

informed consent form and agreed to have the interview recorded. At the completion of this study, the participants will receive a copy of the findings.

Table 3

Participant Interview Dates, Method, Length of Recorded Interview

Participant	Interview Date	Interview Method	Length of Recorded Interview (hours:minutes:seconds)
P1	January 28, 2019	In-person	1:07:49
P2	January 31, 2019	In-person	53:04
P3	February 1, 2019	In-person	1:07:28
P4	February 22, 2019	In-person	1:17:36
P5	March 1, 2019	Phone	1:18:56

Data Analysis

After collecting the data via open-ended interviews, this study employed transcendental phenomenological reduction to analyze the data. Moustakas' (1994) four-step process of (a) bracketing, (b) horizontalizing, (c) clustering, and (d) organizing was used to identify the essence of the lived experience of therapeutic community service providers in Brazil. Conscious of her personal biases, values, and experiences that have shaped her biases, before reviewing the interviews audio recordings, the principal investigator bracketed the objective world to the best of her ability (Moustakas, 1995; Schmitt, 1959). Each interview was then transcribed onto a separate password-protected Microsoft Word document. Each interview was listened to while reviewing the typed transcription at least two times to ensure precision of the transcription and to prepare the principal investigator to identify the horizons. Participants were then invited to review the final version of the transcript of their recorded interview and, if applicable, provide any suggested edits. Next, a line-by-line analysis was conducted on each of the

transcriptions to identify the horizons or textural meanings of the data (Moustakas, 1994). After identifying the horizons, the principal investigator highlighted each of the textural meanings of the phenomenon in the respective password-protected Microsoft Word document. Before transferring the identified horizons to a password-protected Microsoft Excel spreadsheet, the principal investigator ensured all participant identifiers were removed from the text. Grouped by participant and interview question number, the horizons were added to the spreadsheet. After the first four interviews were conducted and horizons identified and transferred to the spreadsheet, the horizons were then grouped into clusters and sub-clusters (Moustakas, 1994). The principal investigator designated a name for each theme according to the literature review and verbiage utilized in the transcripts.

After analyzing and determining the themes and sub-themes for each of the first four interview transcripts, it was determined that new significant insights had not emerged in the fourth interview (Creswell, 2014). The principal investigator completed and transcribed the fifth interview that was in-progress of being scheduled and then determined saturation had been achieved. Next, to validate the data analysis process, the principal investigator employed an inter-rater review process to verify the validity and reliability of the research (Morse et al., 2002).

Inter-rater Review Process

The two peer reviewers were sent a password-protected Microsoft Excel spreadsheet of the data analysis and a copy of the study's research questions and interview questions. The reviewers were asked to provide feedback on the naming conventions used for each of the themes and sub-themes from the first three interviews'

data. Consensus between the principal investigator and the two peer reviewers was reached regarding feedback obtained, therefore, an expert reviewer was not needed. The results of the inter-rater review process were then applied to data from the fourth and fifth participants.

Table 4

Inter-rater Coding Edit Recommendations

Interview Question	Horizon	Cluster	Move To
2	Build trust with family	Cluster: Family Care: Education & Preparation	Cluster: Family Care: Education & Preparation Sub-cluster: Improve relationship and trust between the family & resident

Note. This table demonstrates feedback provided by the inter-rater peer reviewers regarding the principal investigator's initial coded spreadsheet.

Data Display

In order to display the data and findings, the following sections provide an analysis of each research question and the corresponding interview questions. The common themes that emerged from the responses of each interview question are described and supported with tables and direct quotes from the data. From the 11 interview questions, 25 common themes emerged and are displayed. To protect the anonymity of each participant, the participants are referred to as P1, P2, P3, P4, and P5, in accordance with the interview order.

Research Question One

“What strategies and practices are employed by therapeutic community service providers in their respective organizations?” was the first research question asked in

this study. Four interview questions corresponding to RQ1 were asked to the interview participants and utilized to provide an answer to the research question:

- ***IQ 1:*** What business strategies and/or practices helped you be successful in your organization?
- ***IQ 2:*** Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider.
- ***IQ 3:*** Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider.
- ***IQ 4:*** What personal characteristics prepared you in your role as a therapeutic community service provider?

After collecting the responses from all five interview participants, the data was analyzed and resulted in common themes from the responses of each interview question.

Interview question 1. What business strategies and/or practices helped you be successful in your organization? Participant responses to IQ1 resulted in a total of two common themes. The themes that emerged from the analysis are: a) Operational Best Practices and Continuous Improvement and b) Therapy and Mutual Support Groups (see Figure 1).

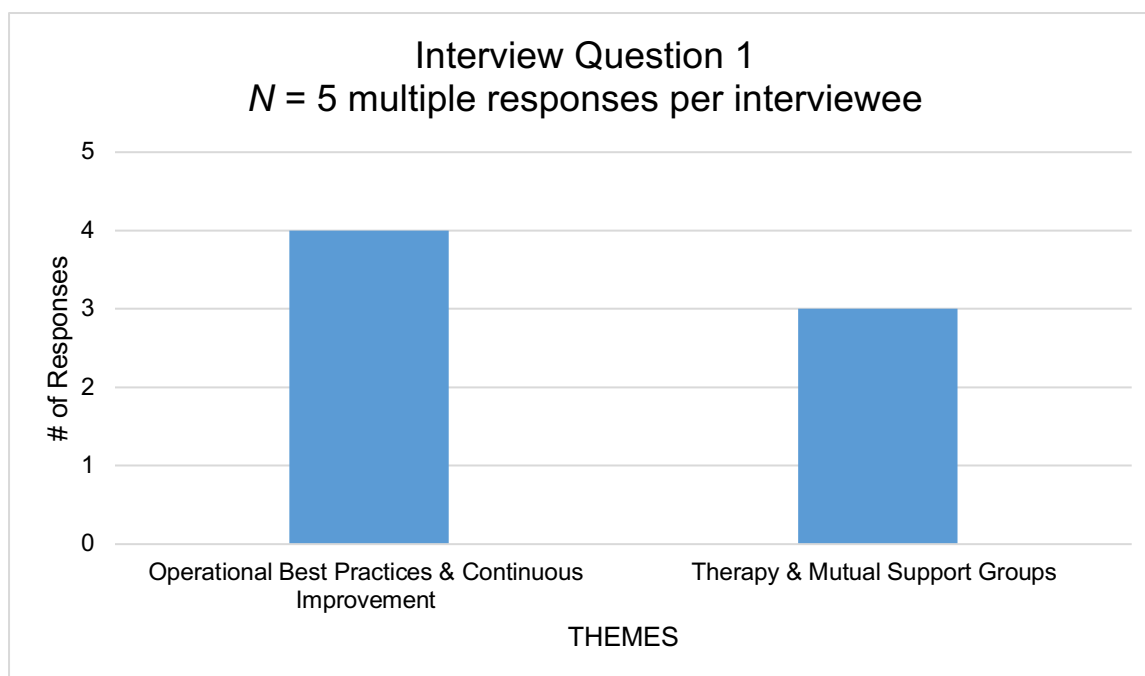


Figure 1. Themes that emerged on practices and strategies for success in therapeutic communities.

Operational best practices and continuous improvement. The most significant strategy and practice employed by service providers in therapeutic communities is operational best practices and continuous organizational improvement. The analysis demonstrated four of the five participants (80%) indicated the need for service providers to intentionally improve their organizations, with physical expansion and increase the love and attention given to holistically supporting the residents (P1, P2, P4, P5). The following quote demonstrates the attentiveness given to strategically expand the organization:

“If there is greater demand, more treatment units are opened in strategic places for the recovery and removal of inmates from the main traffic points” (P5, personal communication, March 1, 2019).

Additionally, in the following statement, P4 details the strategy of focusing on various needs of the resident and the root problem of the substance abuse:

“First, we have to know the person we will receive and define it... We started to work on the addiction problems but not aiming for the drugs because the drugs aren’t the main problem of the people, people are the main problem. We are treating humans, not drugs. So, one of my strategies is to focus on personal care, human care, recovering bondages, reaching families, giving all the emotional support the human being needs. And that’s why the project began to make a lot of sense” (P4, personal communication, February 22, 2019).

Therapy and mutual support groups. Three out of the five participants (60%) indicated the importance of therapy and mutual support groups for residents in their respective therapeutic communities. Below are four elements of the service providers’ strategies and practices employed regarding therapy and mutual support groups:

- Work as therapy (P1)
- Psychological therapy (P1, P3)
- Mutual support groups or programs such as the 12 Steps, Alcoholics Anonymous, Narcotics Anonymous, Relapse Prevention, and Amor Exigente (P1, P3, P5)
- Spiritual support opportunities (P1)

Three of the participants (60%) indicated the importance of implementing a mutual support group or program as a strategy for the therapeutic community framework. The following quote from P3 demonstrates how the mutual support groups and programs are implemented in one therapeutic community:

“So, they start the 12 steps when they are there for about a month. After completing a month there, they start the 12 steps. When they are on the 4th step

they start the [relapse prevention program]. So, everyone is like that, they need to start the 12 steps program first, and then when they are on about the 4th step they can start the [relapse prevention]” (P3, personal communication, February 1, 2019).

Interview question 2. Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider. A total of two common themes derived from the analysis of the five participants’ responses to IQ2. The following themes emerged: a) Consistent and Collaborative Culture and b) Family Care: Education and Preparation (see Figure 2).

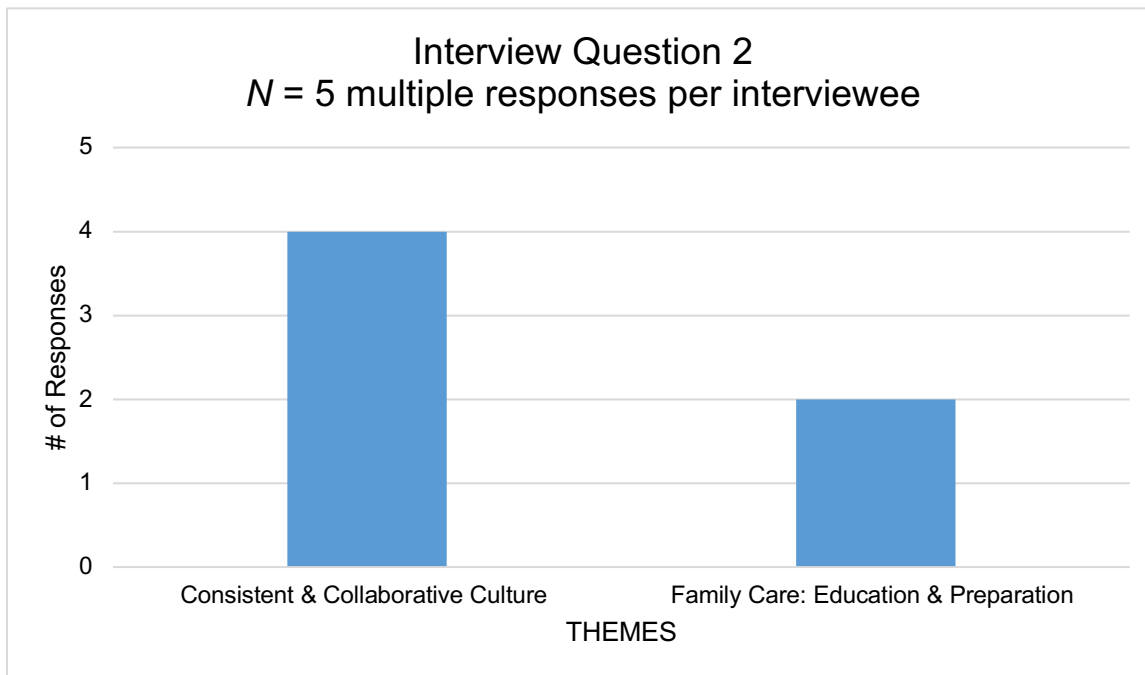


Figure 2. Themes that emerged on leadership practices and strategies for success as a therapeutic community service provider.

Consistent and collaborative culture. The first service provider strategy and practice for a successful therapeutic community is consistent and collaborative culture. Four out of the five participants (80%) indicated that having a consistent and collaborative culture are essential (P1, P3, P4, P5).

“It has to be consistent. And it’s not been that consistent... we need to be tight and say the same language to them. That’s the principle, ehh the principal strategy” (P3, personal communication, February 1, 2019).

In collective collaboration with the other service providers, P4 leads his therapeutic community.

“I believe that we are together, I know the hierarchy and where I am in the hierarchy but we are together... I can’t do it alone. All of my team is important” (P4, personal communication, February 22, 2019).

Family care: education and preparation. The second service provider strategy for a successful therapeutic community is family care: education and preparation. Two out of the five participants (40%) indicated the need for the following:

- Education for the families about the residents’ needs and root problem (P3, P5)
- Improvement in relationship and trust between the family and resident (P3, P5)

P3 explains the lack of understanding families tend to have regarding the root issue for someone with substance abuse problems.

“Usually what happens is the family doesn’t understand the problem, the disease. They don’t understand that it’s a disease. So, when we call them to go there, so I can talk to them, the team, but it’s also pretty much me with them to teach them a little bit about the disease... usually when they go there they are not very good with their families, the bond is not so good so we need to do this work together, and it’s pretty effective, it’s pretty effective, because they, I think

they start to trust a little bit more, the family, in what we say to them, and what is happening to the patient, the resident, so they get a little bit close to us” (P3, personal communication, February 1, 2019).

Interview question 3. Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider. After the analysis of all five participant responses to IQ3, one common theme was determined. The theme that emerged is professional, educational, and personal preparation (see Figure 3).

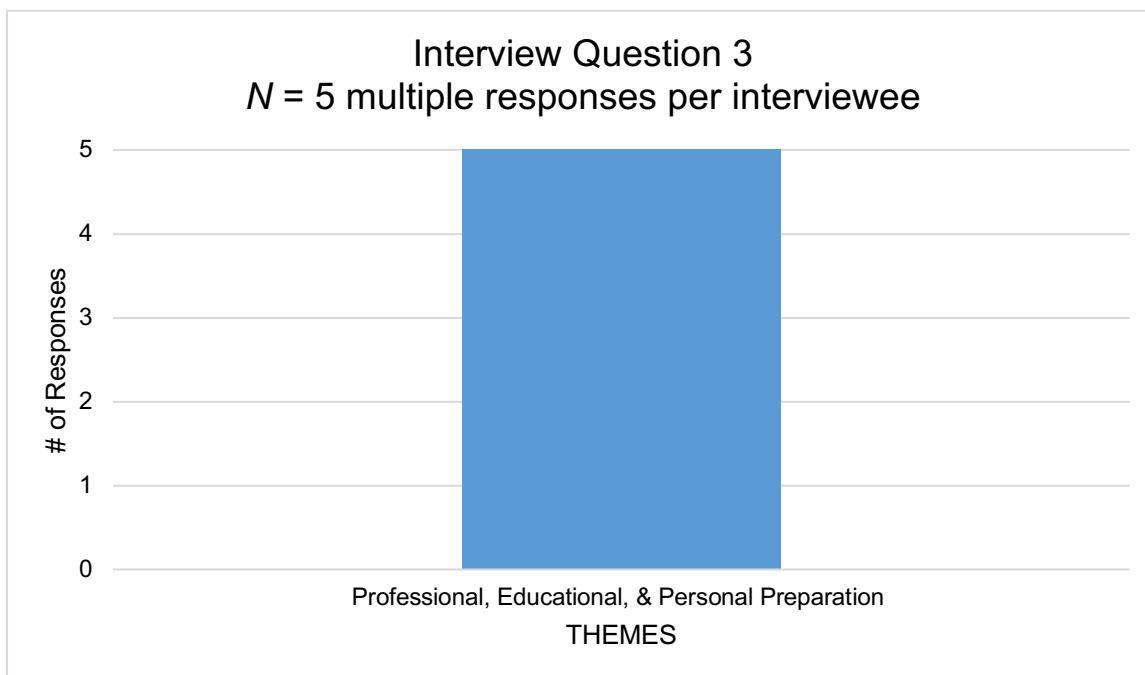


Figure 3. Themes that emerged on education/training and work experiences that prepared therapeutic community service providers.

Professional, educational, and personal preparation. The professional, educational, and personal preparation that service providers experience impacts their role in the therapeutic community. The following statements provide insights into the work experiences, education and personal preparation of all the service provider participants (100%):

- Diverse professional and academic experience (P1, P2, P3, P4, P5)
- Continuing education from FEBRACT training and courses (P2, P3, P4, P5) and other organizations, such as the Freemind Conference, FLACT, and DENARC (P2, P4)
- Personal connection to substance abuse that ignites a passion for substance abusers (P1, P2, P4, P5)

There are few consistencies in the academic experiences of the participants and little to no consistencies among their professional experiences as seen in Table 5. However, four of the five participants (80%) noted FEBRACT's continuing education courses and training to be significant to their role as service providers.

Table 5

Participants' Professional, Academic, and Continuing Education

Participant		Previous Professional Experience	Academic Experience	Current Continuing Education
P1	Banking		Business Administration Finance Specialization in Drugs	N/A
P2	Chaplain Entrepreneur Prison Work		Social Work Courses in Chemical Dependence	FEBRACT training Freemind Conference FLACT DENARC
P3	Psychologist		Psychology Specialization in Substance Abuse & Psychopathology	FEBRACT training
P4	Internships with Therapeutic Communities		Public Management	FEBRACT training DENARC
P5	Flight Attendant		MBA in Administration & Marketing Nursing Technician Flight Attendant Technician Specialization in Surgical Instrumentation Children's Education	FEBRACT training

All of the participants (100%) noted the ability to transfer skills from previous professional experiences to their present role in a therapeutic community.

“[Because of my former job at the bank,] I know how to wait in the moment when it’s changing like now with the new President, new government, so we wait for the right moment to deal with them and this helps us to continue working with the government, the state government, the federal government, and the city government” (P1, personal communication, January 28, 2019).

Four out of the five participants (80%) acknowledged FEBRACT’s training and courses, although an expectation in order to maintain affiliation with FEBRACT, as a consistent opportunity for continuing education.

“FEBRACT also gives a lot of courses about substance abuse. And every year, they do 3 or 4 courses about that so everyone from all the communities go, only the ones that work at the communities from FEBRACT. And it’s always in XXX, so we have a lot of these courses to go, it’s like an obligation” (P3, personal communication, February 1, 2019).

When asked to describe the education/training or work experience that prepared the participant for their respective role in the therapeutic community, four of the participants (80%) shared their personal connection to substance abuse.

“I have son who is now 30 years old and is in jail. And when he was 15 to 16 he began to use drugs and I learned how to use with drugs in the very hard moment because I’m working and dealing with him... he began to traffic so he has been arrested for the first time and he deal with his dependence and then he came out of the prison and he unfortunately killed someone, not someone, his only child

with two years old, and now he is facing another prison for twenty years, he was in jail for almost five and that is my training... And I never met someone who doesn't have something in his or her past with drugs. Nobody came here for nothing. I came here because of my son" (P1, personal communication, January 28, 2019).

P2 has a personal testimony of substance use to sobriety that motivated him and his wife to found a therapeutic community.

"The strongest part is that I have lived the addicted life and I know about the world of drug and crime, so this dialogue is not superficial" (P2, personal communication, January 31, 2019).

P4 does not have a personal experience using substances but grew-up around substance abusers and witnessed the affects substance abuse has on a community.

"The first experience is life. I am not an addict or a chemical dependent. I had an experience in my infancy and [youth] losing friends to this life..." (P4, personal communication, February 22, 2019).

With an alcoholic father, P5's motivation for entering the substance abuse field is very personal.

"Here, every people have someone in the family with an addiction... I am working about the drug in my house, in my home, with my family, you understand, my father is an alcoholic. Then, I am study about this all my life, in school, in my home, with my friends, I am talking about this, then I study about this in being a nurse" (P5, personal communication, March 1, 2019).

Interview question 4. What personal characteristics prepared you in your role as a therapeutic community service provider? One common theme emerged from the analysis of the five participants' (100%) responses to IQ4. The theme that emerged is: Servant Leader Characteristics (see Figure 4).

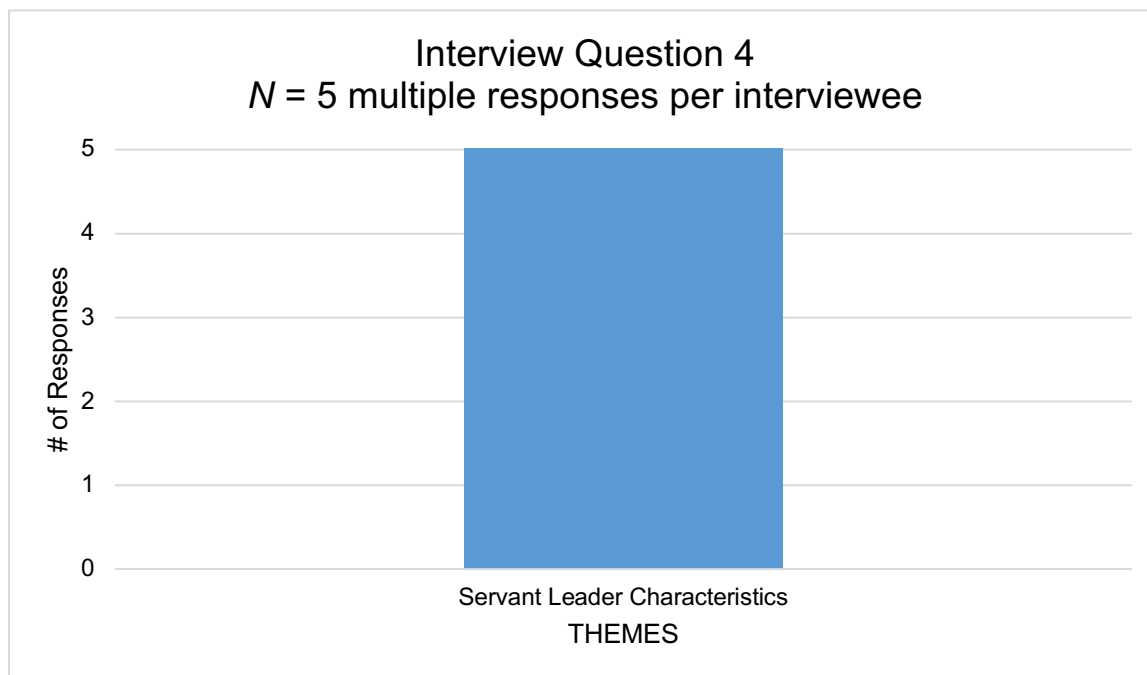


Figure 4. Themes that emerged on personal characteristics that prepared therapeutic community service providers.

Servant leader characteristics. The personal characteristics that prepared service providers for working in a therapeutic community align with characteristics that describe a servant leader. All five of the participants (100%) indicated that their role in the therapeutic community is resident-centered. The following phrases describe additional insight into the strategies and practices of service providers:

- Be non-judgmental (P3, P4, P5)
- Lovingly, compassionately, humbly, and empathetically value the residents (P2, P4, P5)

- Have a vision for the therapeutic community, equip others, and continuously learn (P1, P4)

Three of the participants (60%) indicated the importance of being non-judgmental towards the residents, their past and present actions.

“Even though they make mistakes, you still believe in them and never judge them for whatever mistakes they make because by not judging and believing them, he [the resident] can actually become a true leader and the others can follow this leadership and have somewhere to go back to and this leadership will give him opportunity, opportunity that comes from that belief... I am today in a position of leadership but I am not the reason for the truth and the life” (P4, personal communication, February 22, 2019).

Research question one summary. The first research question asked, “What strategies and practices are employed by therapeutic community service providers in their respective organizations?”. The four interview questions that were asked in correspondence with RQ1 were:

- **IQ 1:** What business strategies and/or practices helped you be successful in your organization?
- **IQ 2:** Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider.
- **IQ 3:** Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider.
- **IQ 4:** What personal characteristics prepared you in your role as a therapeutic community service provider?

A total of six themes unfolded for research question one. The predominant themes that emerged were Operational Best Practices and Continuous Improvement; Consistent and Collaborative Culture; Professional, Educational, and Personal Preparation; and Servant Leader Characteristics. Each of the predominant four themes had responses from four or five of the five participants (80-100%). A summary of the themes for research question 1 is located in Table 6.

Table 6

Summary of Themes for Research Question 1.

IQ1. Business Strategies & Practices	IQ2. Leadership Strategies & Practices	IQ3. Life Experience Preparation	IQ4. Personal Characteristics
Operational Best Practices & Continuous Improvement	Consistent & Collaborative Culture	Professional, Educational, & Personal Preparation	Servant Leader Characteristics
Therapy & Mutual Support Groups	Family Care: Education & Preparation		

Research Question Two

“What challenges are faced by therapeutic community service providers in their respective organizations?” was the second research question in this study. The participants’ responses to two interview questions were asked to inform RQ2. The two interview questions are:

- **IQ 5:** What challenges have you faced in leading therapeutic community services within and outside your organization?
- **IQ 6:** How did you overcome these challenges?

Data collected from all five participants for the two interview questions were analyzed for common themes in respect to RQ2.

Interview question 5. What challenges have you faced in leading therapeutic community services within and outside your organization? Three common themes emerged after analyzing responses from IQ5. The themes generated are a) Local, State, and Federal Government, b) Resident Reality, and c) Family Relationships, Communication, and Understanding (see Figure 5).

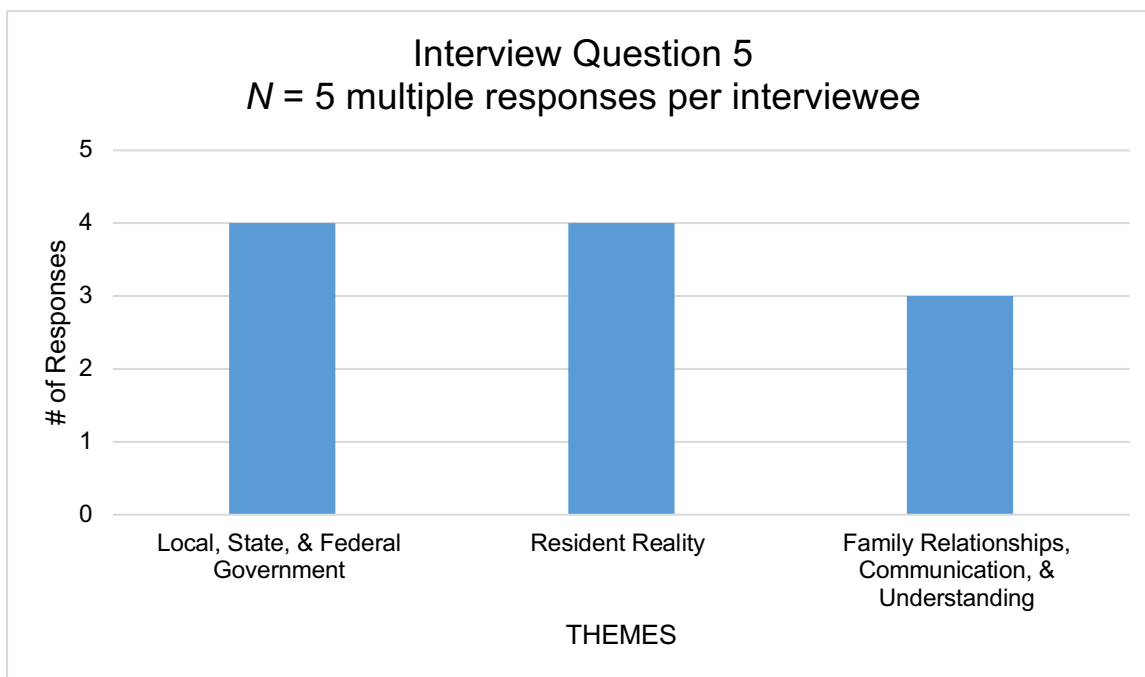


Figure 5. Themes that emerged on challenges service providers face within and outside their therapeutic community.

Local, state, and federal government. A main theme therapeutic community service providers face challenges in leading their organizations is in relation to the local, state, and federal government in Brazil. All five of participants' therapeutic communities are mostly or fully funded by local, state, and federal government programs. However, four of the participants (80%) indicated that the funding they receive is inconsistent or lacking. The following statements further describe the challenge service providers face:

- Inconsistent and lack of funding (P1, P2, P4, P5)
- Rapidly shifting public policy and lack of services (P1, P2, P4, P5)
- Lack of advancement in substance abuse related research (P1, P4)

Two of the therapeutic community service providers stated their fear of losing governmental support (P1, P4) and four of the participants (80%) described how the inconsistencies of funding is one of the most challenging aspects of their work.

“We don’t have a lot of money, the money comes from the government, and all the business we have, a company with whom we have an agreement but most of the agreements are with the government so when we face challenges, the money doesn’t come on the exact day it comes before and that is a problem because we have workers to pay, food to buy, here, because it’s a small city, we negotiate with the commerce here and they deal giving time to us, well the government will pay... wait a moment so we continue buying food, or hygienic products, everything, because we can deal with that, but our main problem is with salary and the workers, we have to negotiate with that. The main problem that we have is with this month, January” (P1, personal communication, January 28, 2019).

P5 described the reality of inconsistent government funding.

“We receive from the government but there are a lot of late payments. In this moment, three months, three months. The government pays for everything but right now three months without... We receive municipal, state, and federal funding. The state has paid but in the day the government is late right now” (P5, personal communication, March 1, 2019).

The second most common challenge related to the local, state, and federal government is in regards to public policy. Three of the participants commented on the lack of post-therapeutic community support and services offered by the government and the reactive social assistance that is currently in place. Every time leaders of the local, state, and federal government change, policy has the potential to rapidly change as well.

“Working with the government is very, very difficult. Because every time a mayor or a president, even a mayor in this city, change, everything changes” (P1, personal communication, January 28, 2019).

Two of the participants (40%) remarked on the lack of the advancement of research regarding substance abuse and therapeutic communities.

“...but we have nothing new in this area so when I subscribe myself in a course, it’s the same information, nothing new, I stopped last year on the second half of the year and I did nothing. I don’t think we have anything new” (P1, personal communication, January 28, 2019).

Resident reality. The second common theme therapeutic community service providers face challenges with in leading their organizations is in relation to the resident reality. Four of the participants (80%) comment on the difficulties faced in working with resident behavior. The following phrases further express the challenges indicated by the reality of the resident:

- Resident behavior, demographics, and fit (P1, P3, P4, P5)
- Individualized and lifelong recovery journey (P1, P2, P3, P4)

Four of the participants (80%) remarked on the bad behavior and habits the residents typically possess when they enter the therapeutic community.

“Their behavior, their bad habits, they come with a lot of bad habits, bad behavior... They have a lot of difficulties in following the rules there, a lot. You have to say one, two, three, four times, and they are not doing that. Behavior is the biggest challenge, and the discipline, it’s very hard” (P3, personal communication, February 1, 2019).

The recovery journey is individual and has no medicinal cure.

“We say who has high blood pressure, takes a medicine to stabilize it, chemical dependence doesn’t have a medicine, the medicine is community” (P5, personal communication, March 1, 2019).

Family relationships, communication, and understanding. The final common theme that derived from the analysis of the challenges therapeutic community service providers face in leading their organizations is with family relationships, communication, and understanding. Three of the participants (60%) noted challenges faced with the relationship between the resident and their family, concerning boundaries, communication, and simply internal family issues (P1, P3, P5). One of the participants explained that due to their rural location, it is difficult to provide effective support to the families. Two of the participants remarked on the family’s lack of understanding of substance abuse and addiction.

“From outside to inside what’s the biggest challenge? The families. The families it’s only the family. The family is the only problem we have from outside to inside. Family, family. Family. They have a lot of trouble to understand the problem and their sons, or husband’s problem, they think it’s a... falta de vergonha na cara... do you have this expression? It’s like lack of shame, they don’t think it’s a

problem, they think it's something they do because they are bad people. They [families] have this thing where they go, the residents, and they leave them there and they think it's 100% our problem, we are going to cure them there" (P3, personal communication, February 1, 2019).

Interview question 6. How did you overcome these challenges? Five common themes emerged after analyzing IQ6 in relation to RQ2. The five themes are as follows: a) Behavioral Support, b) Reintegration, c) Individualized Care, d) Family Care, and e) Making Ends Meet (see Figure 6).

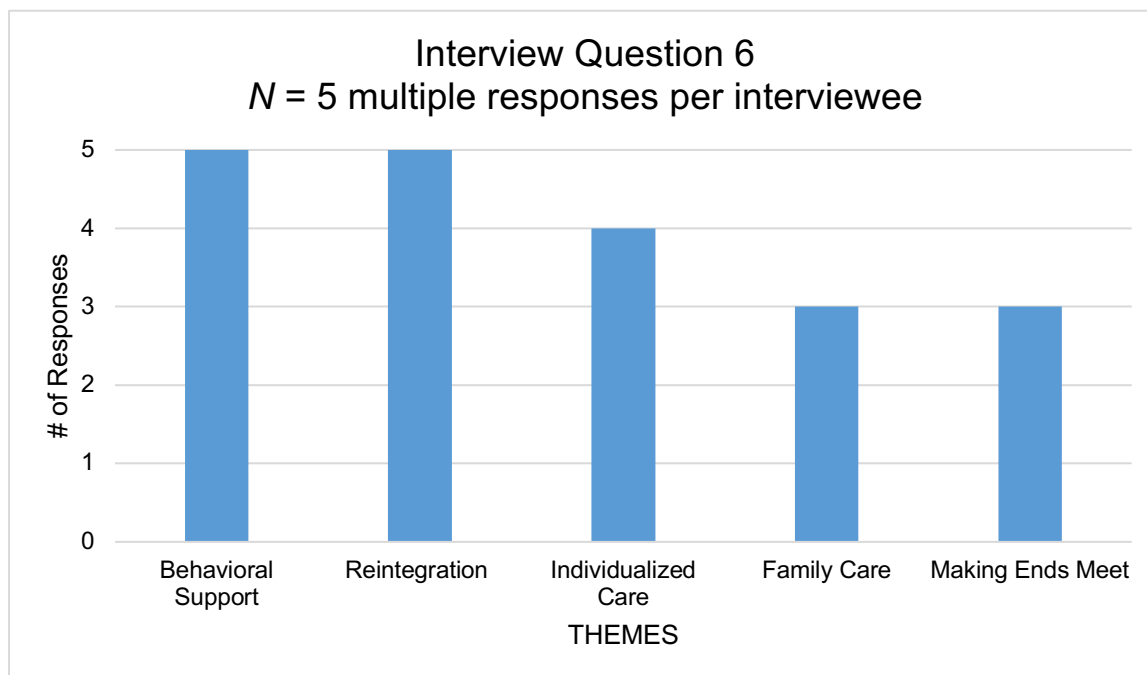


Figure 6. Themes that emerged on how service providers overcome challenges they face within and outside their therapeutic community.

Behavioral support. All five of the participants (100%) noted methods of behavioral support utilized to overcome challenges with resident behavior. The following statements further describe methods service providers use to provide behavioral support:

- Redirect behavioral issues through therapy, group meetings, and education (P2, P3, P4, P5)
- Utilize the community itself to redirect and guide behavior (P1, P3, P4, P5)

At least two of the participants (P2, P5) utilize educational activities and courses to redirect behavior.

“My study in the university was over the synaptic processes in the therapeutic community, I think about, the synaptic process happens repeatedly, you know, in an addict, in the community it shortens this process. So, in the community if you have courses like we have, [crafts], literature, music, to create new synaptic processes, they will re-stabilize and adjust” (P5, personal communication, March 1, 2019).

On an as needed basis, P3 exerts her skills in group therapy meetings with the residents of her therapeutic community to redirect behavioral issues.

“It’s very often, I make a group of them to talk about things like that, ‘let’s talk about healthier things, let’s talk about a movie, let’s talk about some other stuff that is bothering you and not, let’s not talk about trafficking, or alcohol, or streets, or I killed someone, I robbed someone’. They love to talk about stuff like that. Who’s better? Who’s better at robbing? It’s the things that they identify so we keep consistent about ‘don’t talk about that’” (P3, personal communication, February 1, 2019).

Reintegration. All five of the participants (100%) described ways in which they are addressing the challenge of resident relapse through reintegration strategies and

programs. The following phrases describe how service providers are overcoming the challenge of resident reintegration:

- Resident reintegration strategy during therapeutic community program (P1, P3, P4, P5)
- Implementation of a república or residencial terapêutica (P2, P3, P4, P5)

Four of the service providers' therapeutic communities (80%) implement a reintegration process for the residents by gradually allowing the resident additional days outside the therapeutic community to stay with their family.

"They stay here monthly for 4 months and then they begin to go home and return and then we will talk to the family and to them, to see how they deal with the outside society, and family and everything. And prepare for two months we are preparing them to return to society" (P1, personal communication, January 28, 2019).

Only one participant's therapeutic community has an existing república, a halfway house program for residents who complete the therapeutic community program and do not have a place to live post-treatment, as a means of supporting the resident post-therapeutic community.

"We don't have it [government funding] yet for the xxx, that is the house for the kids, just the community and the república. There is two república houses for men who finish here and try to to work again in the market to re-socialize" (P2, personal communication, January 31, 2019).

Three participants (60%) are currently in the process of implementing a halfway house and described their aspirations below.

“We are starting a república because we receive a lot of residents that were living on the streets and lots that doesn’t have family support, so in both cases they pretty much doesn’t have a place to go after they finish the program. I don’t think it’s that common, but apparently, it’s something that it’s growing, because of the demand. All therapeutic communities receive residents that doesn’t have their family support or that comes from the streets. The greatest support will be when the residents are close to finish the program, because the república will give them a sense of ‘I have a place that I can go after my program’. A place that will give them the support they need on that ‘second phase’ of the program, that is when they need to put into practice what they learn through the months they spent at the [therapeutic community]” (P3, personal communication, February 1, 2019).

P4 is in the process of opening a república later this year.

“We had a dream about building a república for the residents who leave here and have nowhere to go because many of them come from the streets and they have no structure outside this place and it becomes pointless to treat them here just to send them out back to the streets where they have no structure... And a república would be where they share the house. It’s going to be up and running in 6 months” (P4, personal communication, February 22, 2019).

The residencial terapêutica, or residential therapy, is the same type of program as a república, a post-therapeutic community halfway house program.

“We are going, we have, our house of residencial terapêutica. We are going to do it in our city here. It will have a capacity of 20 people. We have the 4 communities and a residencial terapêutica. Probably at the middle of the year, depending on the funding... they leave the community, and they don’t have somewhere to go, this person that comes here from the street asking for food, they don’t have somewhere to go so it’s a dream” (P5, personal communication, March 1, 2019).

Individualized care. The third theme that emerged in response to the challenges service providers face in their organizations is individualized care. Four of the participants (80%) stated the importance of being cognizant that the residents are individual human beings with different needs (P1, P2, P4, P5).

“Workers have the challenge of developing care from an individual therapeutic project that considers the needs of people and their real-life context. From this, seek the best way to interact with the individual according to their experience about the singular persons, the singular life” (P5, personal communication, March 1, 2019).

Family care. The fourth theme that emerged in the analysis of how service providers overcome the challenges they face in their organizations is family care. Three of the five participants (60%) described how they offer family psychological support, encouragement, and communication lines between the family and the resident (P3, P4, P5). The following explains how P4 made support and care for the families more accessible given the therapeutic community’s rural location:

“And then, I had another challenge that is because we are staying in a very isolated zone, in the middle of the woods, so we built some kind of base in a neighborhood where the families can go to have therapeutic assistance, psychological assistance, so they won’t have excuses to not come here to have that kind of assistance so they have that place to help as well” (P4, personal communication, February 22, 2019).

Making ends meet. Making ends meet is the fifth theme that surfaced in the analysis of how service providers overcome organizational challenges. Local and family donations are received by therapeutic communities in the form of hygienic products, cigarettes, food, and other goods (P1, P5). The following statements describe how three of the participants (60%) make ends meet:

- Donations from local organizations and resident family/friends, received at the organizations/individuals’ initiative and through service provider requests (P1, P5)
- Ethically and creatively persevere through the financial struggles, seeking to secure additional government funding and maintaining a financial reserve (P1, P2, P5)

P2 describes the resilience required in addressing financial challenges.

“The resilience, I know we live in a country that has a lot of drug stuff, it’s not great, our government doesn’t care about this, if we wanted to take some money and develop our organization, the government doesn’t see the same way that we see, so we need to prove a lot a lot of things for them to get some money...all

these challenges gives resilience for one door that's not open we need to try again and try another way" (P2, personal communication, January 31, 2019).

Research question two summary. The second research question asked, "What challenges are faced by therapeutic community service providers in their respective organizations?". The two interview questions that were asked in correspondence with RQ2 were:

- **IQ 5:** What challenges have you faced in leading therapeutic community services within and outside your organization?
- **IQ 6:** How did you overcome these challenges?

A total of eight themes developed for research question two. The predominant themes that emerged were Local, State, and Federal Government; Resident Reality; Behavioral Support; Reintegration; and Individualized Care. Each of the five predominant themes had responses from four or five of the five participants (80-100%). A summary of the themes for research question 2 is located in Table 7.

Table 7

Summary of Themes for Research Question 2.

IQ5. Service Provider Challenges	IQ6. Overcoming Challenges
Local, State, & Federal Government	Behavioral Support
Resident Reality	Reintegration
Family Relationships, Communication, & Understanding	Individualized Care
	Family Care
	Making Ends Meet

Research Question Three

“How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?” is the third research question that was asked in this study. To answer RQ3, two interview questions were asked to the five participants. The following two interview questions, corresponding with RQ3 were asked:

- ***IQ 7:*** How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?
- ***IQ 8:*** How do you define and measure your success as a therapeutic community service provider?

Data collected from all five participants' responses to the two interview questions were analyzed for common themes.

Interview question 7. How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety? The analysis of the five participant responses yielded five common themes. The themes that emerged are: (a) Post-treatment Follow-up, (b) Program Completion Rate, (c) Sobriety Retention Rate, (d) External Accountability, and (e) Accomplishments (see Figure 7).

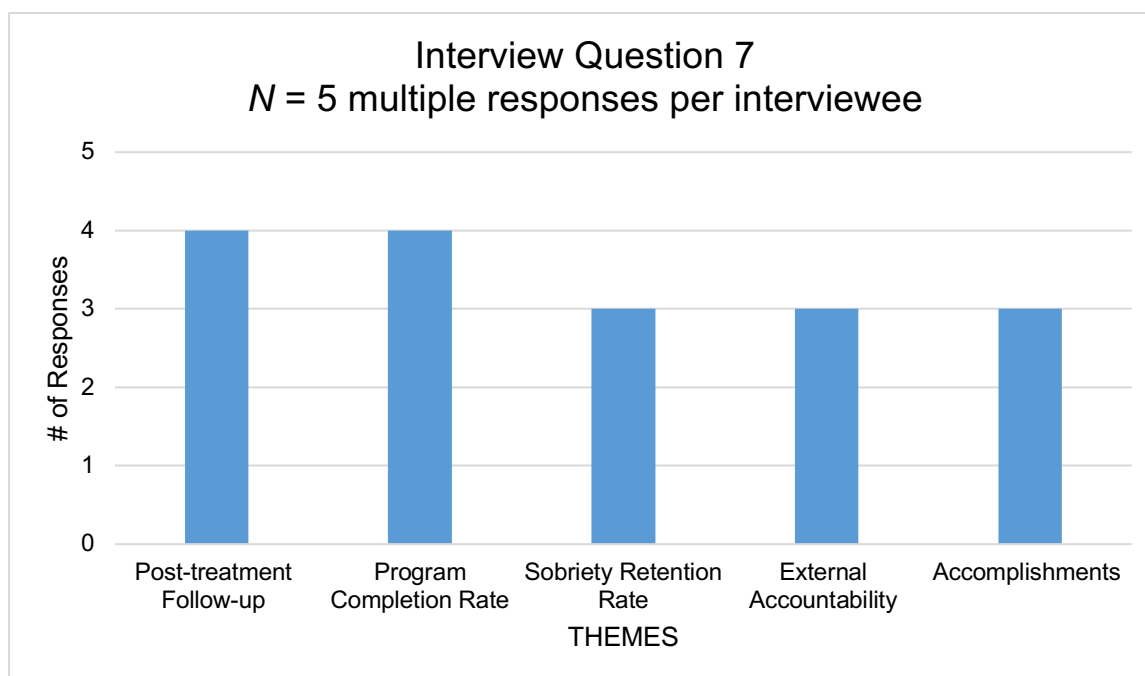


Figure 7. Themes that emerged on how service providers define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety.

Post-treatment follow-up. The first theme that emerged from the data analysis regarding how service providers define and measure success as it pertains to rehabilitative activities to help former residents maintain sobriety is post-treatment follow-up. Four of the five participants (80%) explained their organizational protocol regarding maintaining contact with each former resident for at least the first year after they depart from the program, regardless of if the former resident completed the program or not, as a means of gauging the former resident's sobriety (P1, P2, P3, P4). P2 noted he utilizes a WhatsApp group message to maintain monthly contact with over 170 former residents (personal communication, January 31, 2019). P1 explains that the post-treatment follow-up goes beyond the resident, as the community is a family in itself.

“Drug addicts is a big big family, we never lose contact with them, even if they die or go to prison, or something bad happens, the family returns to us, passing two, three years, we have noticing of that, but regularly, we do it for one year” (P1, personal communication, January 28, 2019).

Program completion rate. The second theme that emerged from the data analysis is measuring success by the residents’ program completion rate. Four of the five participants (80%) commented on the completion rate of residents in their therapeutic community during 2018: 58.6%, 49%, 50%, and 10.7% (P2, P3, P4, P5). P2 remarks on the success of what is considered a high program completion rate.

“We have statistics, I’m finishing the 2018 statistics now...58.6% in self-therapy. That’s our people that finish the therapeutic program...period the guys who come who stay until the finish is about 58%. It’s one of the best in the state out of 100 and a few organizations. 108? I don’t know” (P2, personal communication, January 31, 2019).

Sobriety retention rate. The third theme that emerged is the sobriety retention rate and how it is used as a definition and measurement of success in the therapeutic communities. Three of the five participants (60%) commented on the sobriety retention rate of the former residents (P2, P4, P5). One participant noted 36-37% of former residents maintain sobriety for at least one year (P2, personal communication, January 31, 2019). Another participant explained that only 20% of former residents maintain sobriety and only 10% achieve a quality life:

“...only 20% would actually stay sober so the success of the therapy program, 50% are successful at completing the program but after that, only 20% remain sober because the other ones would have their abstinence crises and relapse. From there, the 20%, 10% have a normal life in society, know they have a problem but know they can live a quality life.” (P4, personal communication, February 22, 2019).

P5 explains how her therapeutic community is not as focused on statistical measurements and that of those who complete the program, 1.07-1.61% maintain sobriety.

“It’s not [measured] about numbers about this. Five years ago, I am study this, and then I have a number, just the last year, 280 people we have stay here, these people just 30 finished the treatment. Of this, just 15 or 10 stay sober. It’s a little number. No? Because I am just thinking, one person sober is a good for us” (P5, personal communication, March 1, 2019).

External accountability. The fourth theme that emerged in the analysis of how service providers define and measure their success pertaining to rehabilitative activities is external accountability. Three of the five participants (60%) noted that by being affiliated with FEBRACT and/or Programa Recomeço, they are required to follow-up with former residents for at least one year after departure from the therapeutic program (P2, P3, P4). P3 remarks on the difficulties experienced in communicating with former residents for one-year post-treatment.

“FEBRACKT, it’s one of their standards, we need to have communication with the resident when they leave for about a year which is hard to do, I’m not going to lie, because how do you maintain communication with someone for a year and how many of them leave treatment and we need to maintain this communication with all of them who leaves” (P3, personal communication, February 1, 2019).

There is inconsistency in the data regarding whether post-treatment follow-up is a standard of FEBRACKT or Programa Recomeço.

“FEBRACKT never demanded the 1-year follow-up but after I joined Programa Recomeço they had a condition of keeping track of the residents. They had this condition for the residents that would be part of the Programa Recomeço program but not for everyone but since I learned that it’s something good to be done, we do it for everyone” (P4, personal communication, February 22, 2019).

Accomplishments. According to three of the participants (60%), the fifth theme that emerged in the analysis of how service providers define and measure their success pertaining to rehabilitative activities is accomplishments (P2, P4, P5). One service provider notes how his therapeutic community is a reference of best practice for other communities.

“These best practices that we call them, it’s a quality that we don’t abandon. This organization in São Paulo is one a reference for others” (P2, personal communication, January 31, 2019).

P5 describes the achievement when a former resident maintains sobriety.

“Discipline, working, and spirituality, [the resident] going for the home, their city, and their family and thinking about the community, 24 hours about community in your home. He came to community before resocialization... He stays in community but he lives with his family in his city, not necessarily in this city because we receive patients from all of Brazil.” (P5, personal communication, March 1, 2019).

Interview question 8. How do you define and measure your success as a therapeutic community service provider? The analysis of the five participant responses yielded one common theme. The theme that emerged is: Striving for Excellence (see Figure 8).

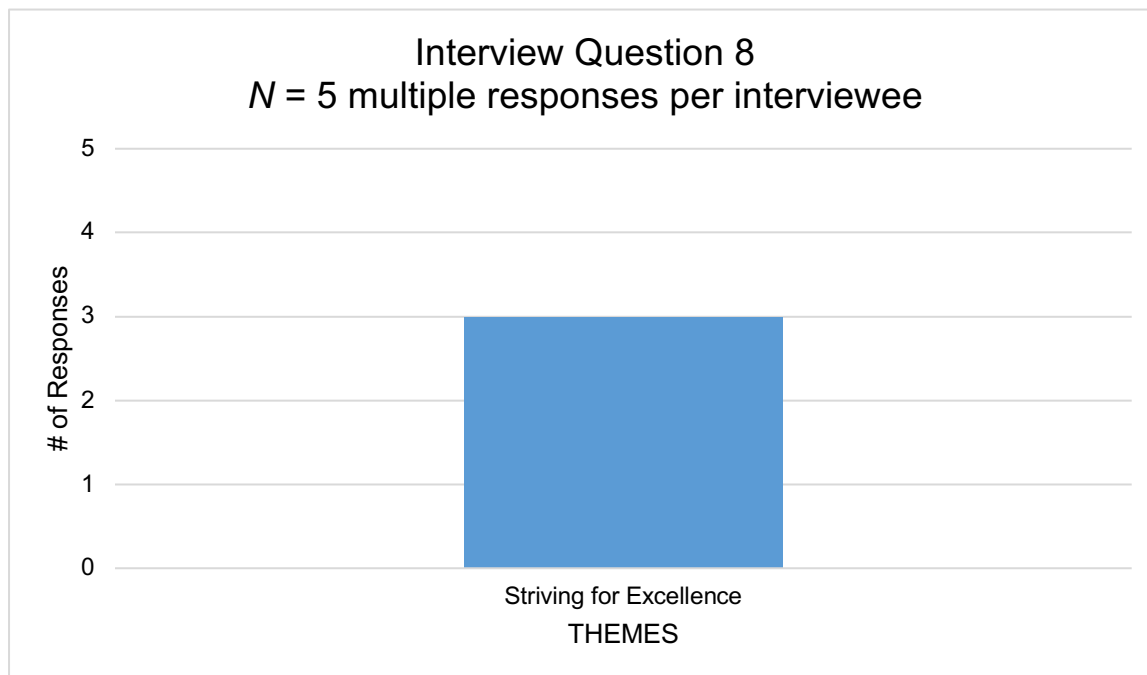


Figure 8. Themes that emerged on how therapeutic community service providers define and measure success their success.

Striving for excellence. The theme that transpired from the analysis of how the participants measure success in their respective roles as therapeutic community service providers is striving for excellence. Striving for excellence through continuous improvement, exceeding standards, maintaining legal compliance, and achieving organizational goals is demonstrated by three of the participants (60%) (P1, P2, P4). In the interview with P4, the participant showed the principal investigator a design plan for the therapeutic community property that had been drawn in 2011-2012 and stays in a visible location from his office desk.

“In 2011-2012, God gave me this vision, and we designed this plan, and 70% is completed! Sometimes I didn’t accomplish it in the time that I wanted but I always accomplish everything I promised and made commitments to finish” (P4, personal communication, February 22, 2019).

P2 describes how his organization is committed to going above and beyond what the law and the affiliate organizations require.

“When we started, we had faith and mission, without funds, structure, without technique, without a team. And the success today, we are a referenced community in São Paulo with best practices. Our team is bigger than the law asks... We don’t want to do just what they ask, we want to do what the mission takes us to do. Each person passing through this community receives more love, more attention” (P2, personal communication, January 31, 2019).

Research question three summary. The third research question asked “How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?”. The two interview questions that were asked in correspondence with RQ3 were:

- **IQ 7:** How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?
- **IQ 8:** How do you define and measure your success as a therapeutic community service provider?

A total of six themes developed for research question three. The predominant themes that emerged were Post-treatment Follow-up and Program Completion Rate. Both of the predominant themes had responses from four of the five participants (80%). A summary of the themes for research question 3 is located in Table 8.

Table 8

Summary of Themes for Research Question 3.

IQ7. Definitions and Measurements of Success for Rehabilitative Activities	IQ8. Service Provider Definitions and Measurements of Success
Post-Treatment Follow-up	Striving for Excellence
Program Completion Rate	
Sobriety Retention Rate	
External Accountability	
Accomplishments	

Research Question Four

“What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?” was the fourth research question asked in this study. Three corresponding interview questions were asked to the participants to inform RQ4. The three interview questions are:

- ***IQ 9:*** What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community?
- ***IQ 10:*** What advice or recommendations would you give to therapeutic community organizations?
- ***IQ 11:*** Is there anything else you would like to add?

Data collected from all five participants’ responses to the three interview questions were analyzed for common themes.

Interview question 9. What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community? Two common themes derived from the analysis of the five participants’ responses to IQ9. The themes that emerged are: a) Prioritize Personal Wellbeing and b) Love for the Residents and the Work (see Figure 9).

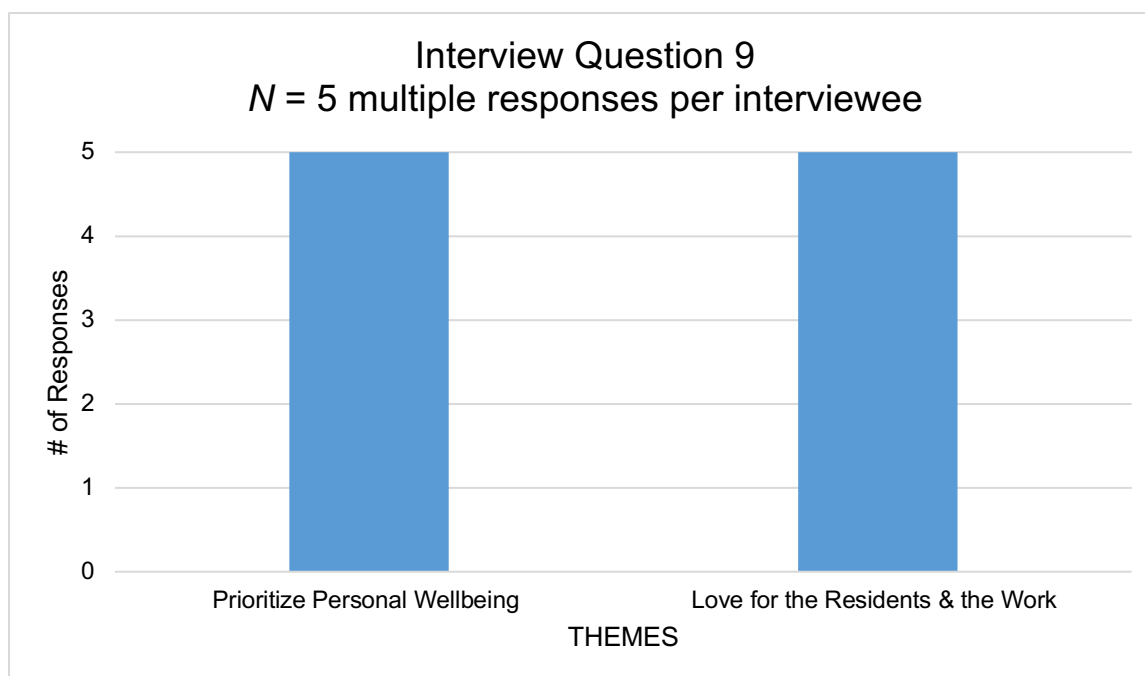


Figure 9. Themes that emerged on advice or recommendations for aspiring leaders of therapeutic communities.

Prioritize personal wellbeing. The first recommendation a service provider would give an aspiring therapeutic community leader is prioritize personal wellbeing. Two of the five participants specifically mentioned the need for service providers to regularly receive therapy (P1, P4). The following statements are recommendations from all of the participants (100%) for individuals aspiring to be therapeutic community leaders:

- Be prepared for a challenging journey, prioritize your wellbeing (P1, P2, P3, P4)
- Believe in the work and have faith (P1, P4, P5)

P1 elaborates on the need to take care of one's emotional needs outside of the therapeutic community.

“Well, keep to you all the feelings that you have about these things and try to resolve them outside the community because here you are a leader and as a leader you have to provide them with positive words, let’s go again, let’s try again, let’s see what we can improve, what we can change to be a good service, or something like that. And these feelings aren’t bad feelings, human feelings, try to make your own therapy outside. You are not involved only with people, you are involved with all the family, and the sons and the mother and all the expectations is on you, on the service” (P1, personal communication, January 28, 2019).

P2 further expounds upon the sacrificial journey of being a service provider.

“And that they understand that a mission like this, is going to take a lot and a lot of your life that they decide that if they want to go out, travel, to have goods, if they want to have a social life, it’s going to interrupt that. If you want to lose your life, come to us, if you want win your life, leave” (P2, personal communication, January 31, 2019).

A psychologist or therapist is recommended for service providers in addition to a spiritual foundation or belief system.

“Everyone should get therapy, everyone should go to the psychologist. I go, my wife goes, my wife does therapy online, ok, do it online, the first thing is to take care, just take care of yourself...You also need to stick to something you believe, you need to believe something, a super power, God, a tree, you need to believe in something. You can’t take care of someone if you don’t take care of yourself,

you can't love someone if you don't love yourself. You need to be in their best shape to help others" (P4, personal communication, February 22, 2019).

Love for the residents and the work. The second recommendation service providers would give to an aspiring therapeutic community leader is love for the residents and the work. All five of the participants (100%) described the love required for work in a therapeutic community. Below are statements that further exhibit how leaders of therapeutic communities should love the residents and the work:

- Humanize the residents and empathetically show them love and acceptance (P1, P2, P3, P5)
- Passionately believe in the cause and do not look for recognition, money (P2, P3, P4, P5)

Two of the participants specifically noted the need to humanize the therapeutic community residents (P2, P5).

"First that the person that comes [to work at the therapeutic community] values humans. They can't see the resident as a human, he's a product, a loss..." (P2, personal communication, January 31, 2019).

Love and acceptance are necessary elements in working with residents of therapeutic communities.

"They reach the substance because of their problems. So, you really have to be that open-minded to that kind of stuff, because it's hard to deal with people who did a lot of bad things in their past... you need to give them freedom, you need to love on them like a child..." (P3, personal communication, February 1, 2019).

Service providers are in a constant battle against substance abuse.

“...and defend the fight, treatment and prevention of this disease” (P5, personal communication, March 1, 2019).

Interview question ten. What advice or recommendations would you give to therapeutic community organizations? Two common themes derived from the analysis of the five participants’ responses to IQ10. The themes that emerged are: a) Therapeutic Community Framework and b) Team Dynamics (see Figure 10).

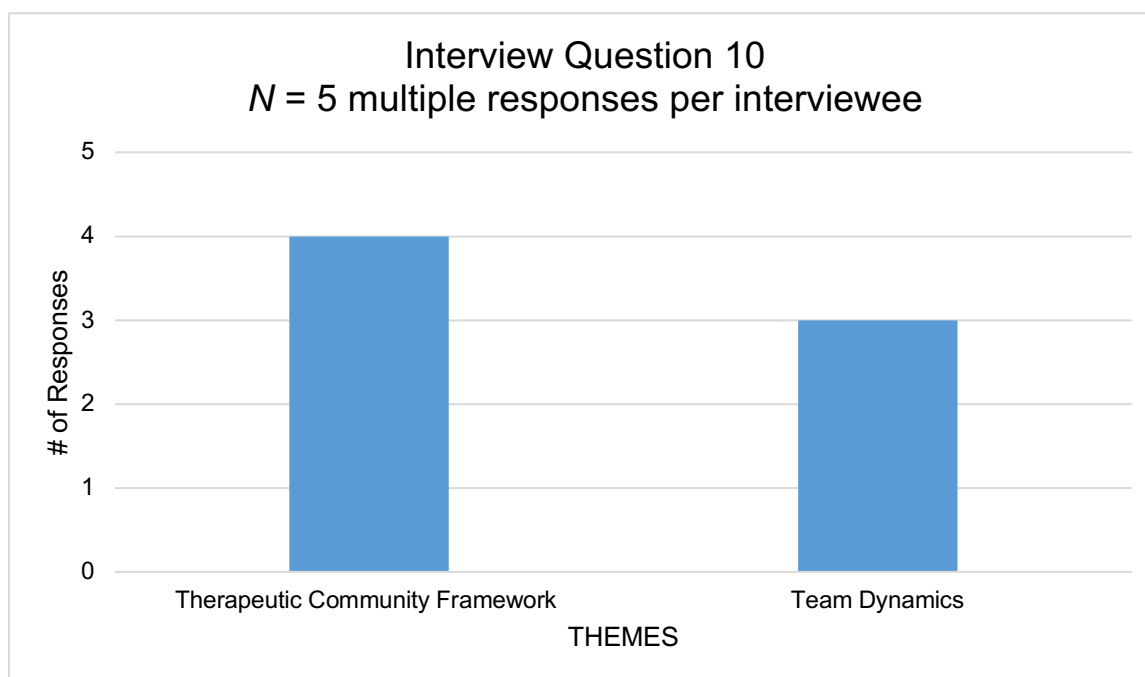


Figure 10. Themes that emerged on advice or recommendations for therapeutic communities.

Therapeutic community framework. The first most notable recommendation service providers would give therapeutic community organizations is related to the therapeutic community framework. The following statements exhibit therapeutic community framework elements four of the participants (80%) recommend organizations consider implementing and practicing:

- Approach resident care individually and holistically (P4, P5)
- Be an ethical organization, always in compliance with public policy (P2, P4)
- Allow religious freedom for residents (P3, P5)

Resident care involves the entire individual not just one aspect of the person.

“And, inside the program, I have to manage and adapt to each of the residents.

In the Bible it talks about the 10 commandments but you have to look at the Bible as a whole not just that section” (P4, personal communication, February 22, 2019).

P4 recommends the therapeutic community framework consistently comply with public policy.

“You have to work with public policy. The program is built pretty much over the recommendation of what the government says we can do. So, we can build on what legal ways we have” (P4, personal communication, February 22, 2019).

Team dynamics. The second most notable recommendation service providers would give therapeutic community organizations is related to team dynamics. Three of the five participants (60%) describe team dynamics within the therapeutic community. The three participants explain that service provider teams need to have clear roles and balance between the service providers with former substance abuse problems and those without a past of substance abuse (P1, P3, P4).

“I don’t believe in having a team of only addicts or only non-addicts, there has to be balance. They need to be equals. Maybe someone who was an addict will have problem understanding something, but that’s not a problem. We complement each other. You need to understand the human. I have two

coordinators, one who was an addict and one who is not. One of them may be a great risk and could have a relapse and destroy an entire team if they were all former addicts, and the other one, they wouldn't completely understand what it is like. So, my recommendation is to make a team who has both but always having a little more attention to those who were addicts, of course, because there's always the cognitive ways, sometimes he may take a little longer, but balance is important. And, whenever you look for employees, never look for employees, look for partnerships" (P4, personal communication, February 22, 2019).

Interview question eleven. Is there anything else you would like to add? One common theme emerged from asking the five participants IQ11, the final interview question. Four of the participants (80%) interviewed described the need for service providers and therapeutic communities to work hard, together (see Figure 11).

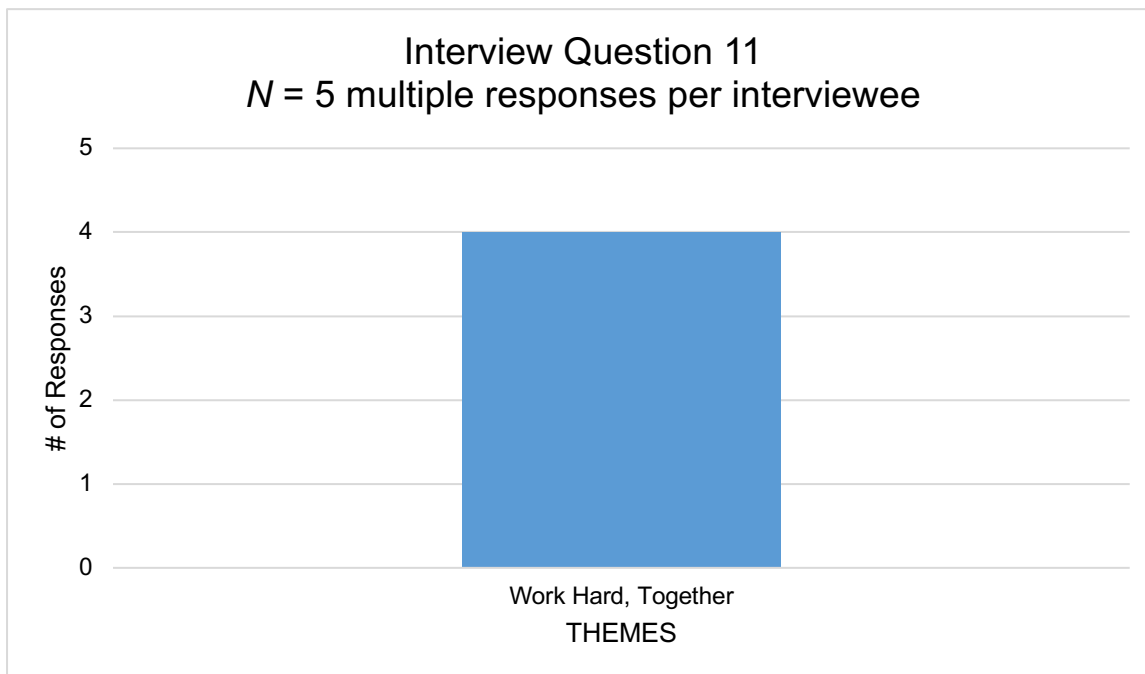


Figure 11. Themes that emerged on additional insight from service providers.

Work hard, together. The most notable additional information provided by four of the five participants (80%) for service providers and therapeutic communities is to work hard, together. Three of the five responses (60%) to question eleven were related to continuous improvement for “the work that never ends” (P2, personal communication, January 31, 2019) (P2, P3, P4). One additional participant added to this theme by sharing how she has witnessed new therapeutic communities experiencing similar problems as her organization: “And we passed through this and sometimes I see some new communities passing through the same problem” (P1, personal communication, January 28). Continuous improvement is a priority for P4 and his team.

“And a few days ago we finally had the república constructed because we have this goal that 50% of the people who finish the treatment, 10% stay clean, and win the process, we want to make that number rise, and the best way to do it is to keep improving services and support and condition for these people because soon enough we’re going to have our streets filled with zombies because the lesions, the injuries they have are sometimes so deep that psychological problems but they don’t have the support for that” (P4, personal communication, February 22, 2019).

Research question four summary. The fourth research question asked “What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?”. The three interview questions that were asked in correspondence with RQ4 were:

- **IQ 9:** What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community?
- **IQ 10:** What advice or recommendations would you give to therapeutic community organizations?
- **IQ 11:** Is there anything else you would like to add?

A total of five themes transpired for research question four. The predominant themes that emerged were Prioritize Personal Wellbeing; Love for the Residents and the Work; Therapeutic Community Framework; and Work Hard, Together. The predominant themes had responses from four or five of the five participants (80-100%). The findings from the fourth research question were service provider-focused and addressed the need to prioritize the service provider's personal wellbeing in addition to the residents. A summary of the themes for research question 4 is located in Table 9.

Table 9

Summary of Themes for Research Question 4

IQ9. Recommendations for Future Therapeutic Community Leaders	IQ10. Recommendations for Therapeutic Communities	IQ11. Additional Information
Prioritize Personal Wellbeing	Therapeutic Community Framework	Work Hard, Together
Love for the Residents & the Work	Team Dynamics	

Chapter 4 Summary

This qualitative phenomenological study was intended to determine practices and strategies employed by therapeutic community service providers, the challenges those service providers face in their respective organizations, the methods service providers use to measure success in rehabilitative activities to help former substance abusers

maintain sobriety, and recommendations service providers have for aspiring therapeutic community leaders. Eleven interview questions were utilized to explore the following four research questions:

RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?

RQ2: What challenges are faced by therapeutic community service providers in their respective organizations?

RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?

RQ4: What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?

After receiving full IRB approval, responses to the 11 interview questions that inform the four research questions were collected through semi-structured interviews with five participants. The principal investigator used a four-step transcendental phenomenological reduction process to analyze the data collected from the interviews. After coding the first three interviews, an inter-rater review process was implemented to validate the coding results of the principal investigator. A total of 25 common themes resulted from the data analysis. A total of 15 predominant themes, themes with responses from four to five of the five participants (80-100%), emerged from the 25 common themes.

Four predominant themes resulted in the analysis of service provider strategies and practices: Operational Best Practices and Continuous Improvement; Consistent and Collaborative Culture; Professional, Educational, and Personal Preparation; and

Servant Leader Characteristics. Each of the four themes of principal strategies and practices had responses from four to five of the five participants (80-100%). Five predominant themes resulted in the analysis of challenges service providers face: Local, State, and Federal Government; Resident Reality; Behavioral Support; Reintegration; and Individualized Care. Each of the five predominant challenges had responses from four or five of the five participants (80-100%). Two predominant themes emerged, Post-treatment Follow-up and Program Completion Rate, as a result of the analysis of measurements of success, each theme with responses from four of the five participants (80%). The four predominant themes that emerged from the service providers' recommendations were Prioritize Personal Wellbeing; Love for the Residents and the Work; Therapeutic Community Framework; and Work Hard, Together. The predominant themes of the recommendations had responses from four or five of the five participants (80-100%). A summary of the 25 common themes is found in Table 10. The following chapter, Chapter 5, will provide additional detail of the data analysis, a discussion of the key findings of the study, implications of the study, and recommendations for future research.

Table 10

Summary of Themes for Four Research Questions

RQ1: Therapeutic Community Strategies & Practices	RQ2: Therapeutic Community Service Provider Challenges	RQ3: Measurements of Success	RQ4: Recommendations
Operational Best Practices & Continuous Improvement	Local, State, & Federal Government	Post-treatment Follow-up	Prioritize Personal Wellbeing
Therapy & Mutual Support Groups	Resident Reality	Program Completion Rate	Love for the Residents & the Work
Consistent & Collaborative Culture	Family Relationships, Communication, & Understanding	Sobriety Retention Rate	Therapeutic Community Framework
Family Care: Education & Preparation	Behavioral Support	External Accountability	Team Dynamics
Professional, Educational, & Personal Preparation	Reintegration	Accomplishments	Work Hard, Together
Servant Leader Characteristics	Individualized Care	Striving for Excellence	
	Family Care		
	Making Ends Meet		

Chapter 5: Conclusions and Recommendations

The purpose of this study was to discern practices and strategies that are employed by therapeutic community service providers, the challenges those service providers face in their respective organizations, the methods service providers use to measure success in rehabilitative activities to help former substance abusers maintain sobriety, and recommendations service providers have for aspiring therapeutic community leaders. The nature of this study was qualitative and used a transcendental phenomenological approach. Phenomenology proved to be a well-suited approach for this study due to the collection of data from a nascent topic (Edmondson & McManus, 2007). The four research questions and 11 open-ended, semi-structured interview questions were led by the literature review to inform the study. The foundational research questions are as follows:

RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?

RQ2: What challenges are faced by therapeutic community service providers in their respective organizations?

RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?

RQ4: What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?

The population of this study derived from service providers of therapeutic communities affiliated with FEBRACT or with the state of Rio Grande do Sul with SDSTJDH and working with male residents. The five participants, all affiliated with

FEBRACT, were recruited and interviewed, four in the state of São Paulo and one in Rio Grande do Sul. Two of the participants are directors and part of the founding team of their respective therapeutic community, and the other three participants are a nurse, psychologist, and human resources manager.

Each participant was asked 11 open-ended interview questions that were tested for validity and reliability by way of prima-facie validity, peer-review validity, a pilot interview session, password-protected recordkeeping, and during data analysis, multiple reviews of the interview transcriptions to ensure accuracy. The five interviews were audio recorded and the principal investigator personally typed the transcriptions following the interviews, reading the transcripts at least twice to ensure precision of the transcriptions.

Next, transcendental phenomenological reduction was implemented through a four-step process: (a) bracketing, (b) horizontalizing, (c) clustering, and (d) organizing (Moustakas, 1994). After the first three interviews were coded and clustered into themes, two peer-reviewers provided feedback on naming conventions and other suggestions regarding the initial coding. Utilizing the peer-reviewers feedback, the remaining two interviews were then coded. In Chapter 4, the common themes of each research question are displayed in tables and figures. This chapter offers a summary and discussion of the findings, implications the research has on subjects related to the findings, and recommendations for future research.

Summary of the Findings

The five service providers who participated in this study were employed at therapeutic communities in São Paulo and Rio Grande do Sul, Brazil. Eleven open-

ended questions were asked to each of the five participants. After analyzing the data collected, twenty-five common themes emerged from the study. Fifteen of the 25 common themes are identified as predominant themes, having an 80-100% response rate from the participants. In identifying strategies and practices, challenges, measures of success, and recommendations of service providers, the following outlines the common themes for each of the 11 interview questions:

1. The active involvement of best practices and continuous improvement and utilization of therapy and mutual support groups were common strategies and practices for success in a therapeutic community.
2. Therapeutic community service providers described leadership strategies and practices with a collective and collaborative culture and gave special attention to family care.
3. A variety of professional, educational, and personal preparation contributed to the readiness of service providers in therapeutic communities.
4. Characteristics that embody a therapeutic community service provider are that of a servant leader.
5. The local, state, and federal government, the resident profile, and recovery journey, and the residents' families surfaced as common challenges faced by service providers in therapeutic communities.
6. To overcome the challenges faced in therapeutic communities, service providers focus on behavioral support, reintegration, individualized care, family care, and making financial and other necessary resources ends meet.

7. Service providers utilize post-treatment follow-up, program completion and sobriety retention rates, external accountability, and accomplishments to define and measure the success of the rehabilitative activities in how they help residents maintain sobriety.
8. As a therapeutic community service provider, success is measured through the ways in which individuals achieve excellence through exceeding minimum standards and attaining organizational goals.
9. An aspiring therapeutic community leader should prioritize personal wellbeing and be dedicated to loving the residents and the work that will consume the role.
10. Therapeutic community organizations are recommended to examine the organizational framework and existing team dynamics.
11. Service providers are recommended to work collectively to achieve the therapeutic community goals.

Discussion of Key Findings

The findings of this study are valuable to current and aspiring therapeutic community service providers. The strategies and information collected can support and improve the success of service providers in equipping recovering substance abusers in the resocialization process. The following discussion of key findings compares the findings from the study to the current literature reviewed in this study. Furthermore, the discussion emphasizes the predominant themes from the five participants' responses.

RQ1: Strategies and practices of therapeutic community service providers.

The goal of the first research question was to understand the current strategies and

practices therapeutic community service providers employ – six common themes derived from responses to RQ1. A total of four predominant themes emerged: Operational Best Practices and Continuous Improvement; Collective & Collaborative Culture; Professional, Educational, & Personal Preparation; and Servant Leadership. Each of the predominant themes had response rates from four or five of the five participants (80-100%).

In therapeutic communities, four of the five participants indicated the need for continuous and intentional improvements (P1, P2, P4, P5). It was evident the service providers were seeking to learn more about addiction recovery and how to best serve the residents. Service providers come from a variety of backgrounds – professionally, educationally, and personally. As the Royal College of Psychiatry (2015) suggests, the service providers in this study are receiving training on a regular basis, however, the training is occurring externally rather than internally. It is undetermined if the training received correlates with the respective therapeutic community's core competencies since each therapeutic community affiliated with FEBRACT is encouraged to operate individualistically. Continuing education with the training FEBRACT requires, on a monthly and annual basis, of those affiliated with the federation, is noted as the primary or only form of continuing education of the participants (P2, P3, P4, P5). One of the participants, in addition to FEBRACT, mentioned the annual Freemind Conference, FLACT, and DENARC as avenues of continuing education (P2).

It is common for former substance abusers with little to no professional credentials to be service providers in therapeutic communities in Brazil (Ribeiro et al., 2013). However, all five of the participants have completed at least an undergraduate

level of college and only one of the participants claimed to have been a former substance abuser (P2). Four participants included their personal connection to substance abuse as they described their education and work experience that has prepared them for their service provider role (P1, P2, P4, P5).

The leadership styles and theories specifically associated with therapeutic community service providers were not found in the literature. Where the nascent literature in this area suggests collective leadership or servant leadership characteristics for service providers, the findings pointed more in line with servant leadership. Service providers showed significant amounts of empathy, awareness for the direction and vision of the therapeutic community, and intentionality to be cognizant and prioritize the wellbeing of the residents, all qualities of servant leaders (Greenleaf, 1977).

Furthermore, a therapeutic community culture that is consistent and collaborative was important to four of the participants (P1, P3, P4, P5). While the literature reviewed does not specifically uncover consistency as an important element in therapeutic community practice, the data aligns with De Leon's (1994) community-as-method model that does reinforce a collective and collaborative therapeutic community design. And, all five of the participants specified the importance of being resident-centered. The service providers share a common vision for helping their residents overcome their addictions and maintain sobriety. The therapeutic communities are individually impacting their local society. FEBRACT, or a similarly formatted organization, has potential to be a vessel that further draws the therapeutic communities and other cross-sector organizations together to more effectively create systemic change in the area of substance abuse in Brazil and beyond (Hanleybrown et al., 2012).

RQ2: Challenges in therapeutic communities. The second research question was intended to comprehend the challenges faced by therapeutic community service providers. Eight common themes derived from responses to RQ2. A total of five predominant themes emerged: Local, State, and Federal Government; Resident Reality; Behavioral Support; Reintegration; and Individualized Care. The predominant themes had response rates from four or five of the five participants (80-100%).

Local, state, and federal government financial support is what all of the participants' therapeutic communities are entirely or almost entirely dependent on to operate (P1, P2, P3, P4, P5), yet, funding is inconsistent and lacking (P1, P2, P4, P5). Although participants descriptively depicted the difficulties their therapeutic communities face with inconsistent funding, the service providers provided few suggestions on how to overcome this challenge. Furthermore, literature regarding Brazilian public policies demonstrates a scarcity in policy related to effective substance abuse issues (Pereira et al., 2017). The rapid shifts in public policy at all levels and lack of available services for individuals in recovery significantly affect the therapeutic community functions (P1, P2, P4, P5). The reintegration technique being implemented this year at three (and currently at one) of the participants' therapeutic communities by way of *república* as an extension of their efforts to support residents in sobriety may also increase the challenges faced regarding funding, policy, and compliance. Additionally, in agreement with the literature reviewed in this study, there is a lack of substance abuse research related to therapeutic communities in the Brazilian context (P1, P4).

Residents arrive at therapeutic communities with a wide range of comorbidities and other challenges. Service providers need to be ready to address and accept

residents with behavioral issues and from different backgrounds, and, at times, dismissing or encouraging a resident who is not aligning with the therapeutic community's objectives to leave (P1, P3, P4, P5). To address behavioral issues, participants utilize psychological therapy, group meetings, educational activities, and the community itself to redirect negative behavior (P2, P3, P4, P5). Four of the participants stated the importance of service providers humanizing the residents (P1, P2, P4, P5). And, one participant who is passionate about humanizing individuals recently created a video to help advocate for the humanization of people living on the streets in Brazil (P2).

In recognizing the differences and complexities each resident presents, an individualized recovery plan for the individual's lifelong recovery journey is a logical response (P1, P2, P3, P4, P5), one that is backed by the literature (Royal College of Psychiatry, 2015; Xavier & Monteiro, 2013). The individualized recovery plan needs to be catered to the therapeutic and educational needs of the individual (Royal College of Psychiatry, 2015). Having a resident reintegration strategy beginning during the therapeutic community program is essential (P1, P3, P4, P5). Several of the participants described the reintegration strategy used in their therapeutic community and how it is set-up to gradually allow a resident to have more days outside the therapeutic community. A developing method of overcoming the challenge of resident reintegration is through the repúblicas, of which Programa Recomeço (2017c) implemented its first in São Paulo in 2017. One of the participants mentioned their current república (P2) and three other participants described a república they are planning to open this year (P3, P4, P5) to assist in reintegration. The concept of having a república option post-therapeutic community is on the rise and a form of structured aftercare separate from

the therapeutic community and easily accessible to the city, unlike most therapeutic communities. The hope in offering lodging for former residents through a república is to bridge the gap towards independent living to further reduce relapse rates. As discussed in the literature, Sannibale et al. (2003) concluded structured aftercare significantly reduces relapse rates.

RQ3: Measures of success in therapeutic communities. The third research question was constructed to determine how therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety. From the data analysis related to RQ3, six common themes emerged. Two predominant themes transpired: Post-treatment Follow-up and Program Completion Rate. The two predominant themes each had response rates of four of the five participants (80%).

All of the participants indicated direct methods of measurement that are used to define and measure the success of their residents. Program completion rates of participants are what would appear low (10.7-58.6%) yet all respondents remarked positively about their percentage (P2, P3, P4, P5). Four of the participants mentioned how they track their former residents for at least one year after they leave the therapeutic community. However, there was only reference of checking on the former resident's sobriety and not on their involvement in a form of aftercare which Vanderplasschen et al. (2013) states is a predictor of recovery status and reduces relapse rates. The four participants from São Paulo indicated that FEBRACT and Programa Recomeço hold organizations affiliated with them accountable for measuring their effectiveness through the one-year tracking strategy (P1, P2, P3, P4).

Furthermore, the quality of life of former residents was explained by one participant as being achieved by 10% of the individuals who complete the program, which in this therapeutic community is about 50%, and therefore, approximately 1 out of every 10 men who enter the therapeutic community (P4). If more effective aftercare services were implemented and former residents actively participated in them, the literature explains their overall quality of life would improve (Arbour, Hambley, & Ho, 2011; Duffy & Baldwin, 2013; Laudet, Morgan, & White, 2006; Sannibale et al., 2003).

RQ4: Recommendations for aspiring therapeutic community leaders. The fourth and final research question was designed to acquire recommendations for aspiring therapeutic community leaders. Five common themes developed from the responses to RQ4. The four predominant themes included: Prioritize Personal Wellbeing; Love for the Residents and the Work; Therapeutic Community Framework; and Work Hard, Together. The four predominant themes for RQ4 had responses from four or five of the five participants (80-100%).

The work of a service provider is emotionally, mentally, spiritually, and physically challenging (P1, P2, P3, P4). All five of the participants specified the importance of a service provider prioritizing their wellbeing. The literature discusses the role spirituality can play in emotionally supporting an individual in recovery (Narvaez et al., 2015) and spirituality, that is typically foundational in a therapeutic community's culture in Brazil, may also apply to the service provider's wellbeing (P1, P4, P5). Two of the participants specifically recommended that service providers receive therapy regularly to maintain personal health (P1, P4). Love for the work and the residents is a recommendation all participants make for aspiring service providers. An *agape*, unconditional, type of love

should be shown to the residents through empathy, acceptance, and humanization (P1, P2, P3, P5). A service provider should believe passionately in the fight against substance abuse and not look for material rewards because it is not a realistic expectation (P2, P3, P4, P5). Within the therapeutic community framework, approach resident care individually, holistically, and allow religious freedom (P3, P4, P5). Although public policy shifts quickly, service providers must agilely adapt and comply so that the organization remains ethically sound (P2, P4).

Summary of key findings. Each of the four research questions produced a unique discussion regarding the lived experience of therapeutic community service providers. The table below shows a summary of the key elements discussed in the literature that emerged in the discussion of the key findings. In addition, the table includes four specific theoretical frameworks that emerged: servant leadership, community-as-method, collective impact, and individualized recovery.

Table 11

Summary of Relevant Literature and Theoretical Frameworks

Literature	Theoretical Frameworks
<ul style="list-style-type: none"> • Regular training for service providers (Royal College of Psychiatry, 2015) • Unlike Ribeiro et al. (2013) suggest, FEBRACT affiliated service providers have professional credentials • Lack of Brazilian policy effectively addressing substance abuse issues (Pereira et al., 2017) • Resident reintegration through repúblicas (Programa Recomeço, 2017c) • Structured aftercare reduces relapse rates, is a predictor of recovery status (Sannibale et al., 2003; Vanderplasschen et al., 2013), and it is a factor in the improvement of overall quality of life for individuals in recovery (Arbour, Hambley, & Ho, 2011; Duffy & Baldwin, 2013; Laudet, Morgan, & White, 2006; Sannibale et al., 2003) • Role of spirituality in a therapeutic community (Narvaez et al., 2015) 	<ul style="list-style-type: none"> • Service providers as servant leaders (Greenleaf, 1977) • Community-as-method therapeutic community model, reinforcing a collective and collaborative therapeutic community design (De Leon, 1994) • Collective impact for systemic change (Hanleybrown et al., 2012) • Individualized recovery plan for therapeutic community residents (Royal College of Psychiatry, 2015; Xavier & Monteiro, 2013)

Implications of the Study

This study was dedicated to uncovering the lived experiences of service providers in therapeutic communities due to the limited amount of published research contributing to this area in Brazil. Strategies and practices, challenges, measures of success, and recommendations were key in enhancing the current research for individuals aspiring to work in therapeutic communities. Additionally, implications from this study can be made for men and women in recovery, Brazil and other countries throughout the world, rehabilitation facility service providers and leadership, and government policy.

Implications for men and women in recovery. Individuals in recovery from substance abuse have diverse backgrounds, individual challenges, and they depend on the recovery system to provide the support they need to achieve sobriety and be equipped to live a quality life (Phillips & Fraizer, 2018). However, from this study's findings, significant improvements are evidently needed to advance the effectiveness of the current recovery system. With about half of therapeutic community residents completing the recovery program, a small percentage of those maintaining sobriety, and an even smaller amount living a quality life post-treatment, changes must take place. Addiction recovery organizations can use the study's findings to strengthen their programs to better meet the needs of individuals in recovery by assessing how areas such as behavioral support, reintegration, individualized care, and family care are being implemented and evaluated.

Implications for Brazil and beyond. This study revealed ways in which therapeutic communities and other addiction recovery efforts in Brazil have an

opportunity to collectively impact the eradication of substance abuse. Although this study shows the support the government provides therapeutic communities is insufficient, the desire for the government to continue partnering with therapeutic communities is evident. In addition to the financial support from the local, state, and federal government, FEBRACT, Programa Recomeço, and other organizations could work more intently together towards systemic change by creating a common agenda, sharing measures, mutually reinforcing activities, having clear communication lines, and establishing a backbone of support (Hanleybrown et al., 2012). A systemic change has potential to impact substance abuse on a larger scale. Brazil could rise as a point of reference and support for change in countries surrounding Brazil and beyond. Collectively focusing on the systemic issue may in turn uncover root problems of substance abuse and encourage initiatives to address the root issues that surface.

Implications for rehabilitation facility service providers. Research on rehabilitation facilities tends to focus on the organization itself and the individuals the organization serves. However, the participants conveyed the importance of self-care for service providers' emotional, mental, and spiritual wellbeing, primarily through regular therapy or counseling. The service providers must prioritize their wellbeing and have the opportunity to do so in order to sustain the work being done. Moreover, with the attention being given to reintegration through repúblicas, service providers should examine and evaluate strategies utilized to reintegrate residents into society.

Implications for rehabilitation facility leaders. The findings of this study have several implications for rehabilitation facility leaders. The service providers interviewed operate in their organizations in alignment with the collective and communal nature of

operations described in the literature as common in Brazil and the United States, and opposing the hierarchical therapeutic community model in Europe (Vanderplasschen et al., 2014). The literature review showed a gap in information concerning therapeutic community service providers as leaders, their leadership characteristics and style. The findings provide a link between therapeutic community service providers and servant leadership; therefore, this leadership style should be further explored in the context of service providers.

Service providers are changemakers in their societies and carry the responsibility of equipping complex individuals, often with many challenges, to live productively in society and hopefully with a meaningful life. Based on the study's findings, a new substance abuse recovery process has emerged which leaders can use to improve their organizations towards a more effective practice. Rather than an individual transitioning from a therapeutic community directly to independent living, a transitional step has been added to the narrative, what the principal investigator calls a reinsertion community. As therapeutic communities are beginning to recognize the need for a transitional living space, the question remains, is implementing a república going to significantly impact the relapse rate and quality of life of the residents and how might this movement be optimized? This study demonstrates the need for therapeutic community residents to have continued support post-therapeutic community treatment, as a result, Figure 12 offers an addiction recovery framework that differentiates each part of the process: (a) Therapeutic Community, (b) Reinsertion Community, and (c) Independence and Community. To offer a clear segue for an individual from a therapeutic community to independent living, the reinsertion community step is proposed to bridge the two

recovery phases. A reinsertion community is a continuation of the recovery practices an individual learns in the therapeutic community with an additional emphasis on being equipped for a meaningful and productive life once the individual lives independently. Community, core to the therapeutic community model, remains fluid throughout the process and is intended to extend throughout an individual's lifelong recovery. If leaders consider the system in which they are working and identify the areas in need of improvement, an opportunity to create systemic change may arise.

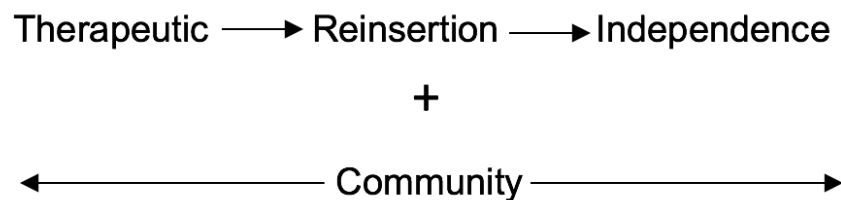


Figure 12. TRI-Community. Copyright 2019 by Lyndsay Phillips.

Implications for government policy. The findings from this study revealed the deficiency in research regarding the relationship between government policy and therapeutic communities. The therapeutic communities are directly affected by policy and highly impacted by the choices the government makes in funding and regulating these organizations. The findings demonstrate the importance of the government to stabilize the financial support provided to the therapeutic communities. To collectively create an impact in response to the complex substance abuse problem in Brazil, effective collaboration between the government, therapeutic community leaders, and substance abuse federations championing and supporting responding organizations, such as FEBRACT, is needed. Policymakers and other policy influencers should

contemplate the issues services providers are experiencing to guide their efforts in improving public policy and prioritize consistency.

Recommendations for Future Research

This phenomenological study interviewed five Brazilian therapeutic community service providers. The purpose of this study was to qualitatively explore the lived experiences of service providers, uncovering strategies, practices, and how they measure their success in working with recovering substance abusers, challenges they face, and recommendations service providers have for one another. The literature in this study related to the addiction crisis in Brazil and how the country has responded to the systemic issue enhanced the data collected through the lived experiences of the five participants, enhancing and adding to the current research. In order to further the knowledge base on therapeutic communities and other addiction recovery methods, the following studies are recommendations for future research.

1. A study that broadens the scope of therapeutic communities beyond Brazil to include service providers in countries such as the United States, the United Kingdom, and New Zealand. This recommendation should enrich the narrative and add value to the findings of this study focused on Brazilian therapeutic communities.
2. A study that focuses on the residents of therapeutic communities in Brazil and monitors the residents beginning with their therapeutic community experience into their life post-treatment. A study examining their lived experience in recovery and quality of life.

3. A study that replicates the research design in this document yet includes non-English speakers. By broadening the pool of prospective participants to include non-English speakers, additional participants would be anticipated.
4. A study that examines directors of Brazilian therapeutic communities. This study would survey directors to explore the recovery strategies and metrics currently used throughout Brazil in therapeutic communities and follow-up with selected participants to expand on how organizations are equipping residents to live sober quality lives post-treatment.

Final Thoughts

The lived experiences gathered from the open and authentic service providers who participated in this study will continue to contribute to the literature in Brazil and beyond. As the substance abuse problem around the world continues to grow, the need for greater understanding of the problem and how to combat it will grow as well. Based on this study, there is significant potential for improvement in Brazil's recovery system, and it is important for collective collaboration across sectors to guide improvements to create systemic change. I believe that more attention and resources need to be given to substance abuse eradication. The current efforts being made in Brazil to support individuals in recovery are responding as best they know how to the symptoms. However, in my opinion, more needs to be done to uncover the root issues behind substance use and abuse, and we must collaboratively act on resolving those issues from the root. If the root problem is not addressed, the response is merely temporary.

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APPENDIX A

Interview Recruitment Email Script

Date: [Day/Month/Year]

Dear Prospective Participant,

My name is Lyndsay Phillips and I am a doctoral candidate in the School of Education and Psychology at Pepperdine University, in California. I am conducting a research study entitled ADDICTION RECOVERY: AN EXPLORATION OF THERAPEUTIC COMMUNITY IMPACT IN BRAZIL. English speakers working in therapeutic communities with male residents in São Paulo and Rio Grande do Sul are invited to participate.

The purpose of this study is to determine how therapeutic community service providers are impacting addiction recovery. This study consists of 11 open-ended interview questions. The interview is anticipated to take 45-60 minutes and it will be audio recorded for data collection purposes. Participation in this study is voluntary. It is based on your interest and availability, and guarantees your complete anonymity in the study's findings.

Are you interested in participating in this study?

If you are interested, I will follow-up immediately with an email to provide detailed information about the nature of the study and include a copy of the interview questions. If at any time you decide you do not wish to participate in the study, you only need to let me know.

Thank you for your participation,

Lyndsay Phillips

Doctoral Candidate in Organizational Leadership
Pepperdine University, Graduate School of Education and Psychology
Malibu, California, United States of America

APPENDIX B

Sample Interview Recruitment Reminder Email Script

Date: [Day/Month/Year]

Dear Prospective Participant,

This email serves as a friendly reminder in regard to previous communication I provided you regarding my research study. I am conducting a research study entitled ADDICTION RECOVERY: AN EXPLORATION OF THERAPEUTIC COMMUNITY IMPACT IN BRAZIL. English speakers working in therapeutic communities with male residents in São Paulo and Rio Grande do Sul are invited to participate.

The purpose of this study is to determine how therapeutic community service providers are impacting addiction recovery. This study consists of 11 open-ended interview questions. The interview is anticipated to take 45-60 minutes and it will be audio recorded for data collection purposes. Participation in this study is voluntary. It is based on your interest and availability, and guarantees your complete anonymity in the study's findings.

If you are interested in participating, please let me know via email and I will follow-up with you regarding next steps.

If you are not interested, please also follow-up via email so that I may remove you from my list.

Let me know if you have any additional questions. Thank you for your consideration!

Kind regards,

Lyndsay Phillips

Doctoral Candidate in Organizational Leadership

Pepperdine University, Graduate School of Education and Psychology

Malibu, California, United States of America

APPENDIX C

Informed Consent

PEPPERDINE UNIVERSITY

(Graduate School of Education and Psychology)

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

ADDICTION RECOVERY: AN EXPLORATION OF THERAPEUTIC COMMUNITY IMPACT IN BRAZIL

You are invited to participate in a research study conducted by Lyndsay Phillips, MA, and Dr. Lani Fraizer at Pepperdine University because you:

12. Are a current service provider of a therapeutic community in Brazil;
13. Are at least 19 years old or older;
14. Work with male substance abusers; and
15. Speak English.

Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. You will be given a copy of this form for your records.

PURPOSE OF THE STUDY

This purpose of this study is to determine:

12. What strategies and practices are employed by therapeutic community service providers in their respective organizations?
13. What challenges are faced by therapeutic community service providers in their respective organizations?
14. How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?
15. What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?

STUDY PROCEDURES

If you volunteer to participate in the study, you will be asked to:

1. Review the open-ended interview questions before the interview
2. Review and sign the informed consent form
3. Respond to the 11 qualitative interview questions in a 45 to 60 minute interview in-person or on a telephone
4. Review the transcribed responses taken from the recording of the interview

Note: Participant must agree to be recorded to participate in the study.

POTENTIAL RISKS AND DISCOMFORTS

There are no known risks to the participants in this study. Potential discomfort may include feeling uncomfortable with questions and fatigue from the duration of the interview.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no payment and/or compensation for participating in this study, there are anticipated benefits to the participant and society:

1. Results of the study will contribute to the specific knowledge and experience of service providers in therapeutic communities implementing strategies to aid addicts in the recovery process.
2. The results of this study will be used to contribute to the literature relating to therapeutic communities and addiction recovery.
3. Each participant will receive a copy of the findings to demonstrate the value provided.

There is no payment and/or compensation for participating in this study.

CONFIDENTIALITY

Your responses and the records collected for the study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected about you. Examples of the types of issues that would require the investigator to break confidentiality are if instances of child abuse or elder abuse are disclosed. Pepperdine University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The data will be stored on a password-protected computer in the principal investigator's place of residence. The data will be stored for a maximum of three years. Any identifiable information

obtained in connection with the study will remain confidential. The interview recordings will be destroyed once they have been transcribed.

PARTICIPATION AND WITHDRAWAL

You are voluntarily deciding whether or not to participate in this research study. You can decide not to be in this research study, or you can stop being in this research study at any time before, during, or after the research begins for any reason. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator or with Pepperdine University or any benefits to which you are entitled.

By emailing your acknowledgement and/or sending a signed copy of this document, you have given your consent to participate in this research. You should print a copy of this page for your records.

EMERGENCY CARE AND COMPENSATION FOR INJURY

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury.

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that I may contact the following individuals if I have any other questions or concerns about this research.

Lyndsay Phillips – Investigator ([REDACTED])
Dr. Lani Fraizer – Dissertation Chairperson ([REDACTED])

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, [REDACTED] or [REDACTED].

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

AUDIO/VIDEO/PHOTOGRAPHS

☐ *I agree to be audio-recorded*

☐ *I do not want to be audio-recorded*

Name of Participant

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

Name of Person Obtaining Consent

Signature of Person Obtaining Consent

Date

APPENDIX D

Interview Questions Process Form

Participant Pseudonym: _____

Age: _____ **State:** São Paulo / Rio Grande do Sul

Gender: M / F

Current role: _____

Therapeutic Community Gender: All Males / Males and Females

Length of tenure in current role: _____

Highest level of education: _____

Interview Question One: What business strategies and/or practices helped you be successful in your organization?

Notes:

Follow-up question(s):

Interview Question Two: Describe the leadership strategies and/or practices that have helped you to be successful as a therapeutic community service provider.

Notes:

Follow-up question(s):

Interview Question Three: Describe the education/training or work experiences that have prepared you to be in your role as a therapeutic community service provider.

Notes:

Follow-up question(s):

Interview Question Four: What personal characteristics prepared you in your role as a therapeutic community service provider?

Notes:

Follow-up question(s):

Interview Question Five: What challenges have you faced in leading therapeutic community services within and outside your organization?

Notes:

Follow-up question(s):

Interview Question Six: How did you overcome these challenges?

Notes:

Follow-up question(s):

Interview Question Seven: How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?

Notes:

Follow-up question(s):

Interview Question Eight: How do you define and measure your success as a therapeutic community service provider?

Notes:

Follow-up question(s):

Interview Question Nine: What advice or recommendations would you give to an individual aspiring to be a leader of a therapeutic community?

Notes:

Follow-up question(s):

Interview Question Ten: What advice or recommendations would you give to therapeutic community organizations?

Notes:

Follow-up question(s):

Interview Question Eleven: Is there anything else you would like to add?

Notes:

Follow-up question(s):

APPENDIX E

Research Questions and Corresponding Interview Questions

Research Questions	Corresponding Interview Questions
RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?	<p>IQ 1: What business strategies and/or practices have helped you be successful in your organization?</p> <p>IQ 2: What leadership practices and/or techniques have helped you be successful as a therapeutic community service provider?</p> <p>IQ 3: What education/training or work experiences prepared you in your role as a therapeutic community service provider?</p> <p>IQ 4: What personal characteristics prepared you in your role as a therapeutic community service provider?</p>
RQ 2: What challenges are faced by therapeutic community service providers in their respective organizations?	<p>IQ 5: What challenges have you faced in leading therapeutic community services within and outside your organization?</p> <p>IQ 6: How did you overcome these challenges?</p>
RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?	<p>IQ 7: How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?</p> <p>IQ 8: How do you define and measure your success as a therapeutic community service provider?</p>
RQ4: What recommendations do therapeutic community service providers provide for aspiring leaders of therapeutic communities?	<p>IQ 9: What advice or recommendations would you give to therapeutic community service providers?</p> <p>IQ 10: What advice or recommendations would you give to therapeutic community organizations?</p> <p>IQ 11: Is there anything else you would like to add?</p>

Research Questions and Corresponding Interview Questions. Note. The table identifies four research questions and corresponding interview questions.

APPENDIX F

Peer Reviewer Email Script

Dear reviewer:

Thank you for agreeing to participate in my research study. The form in the attached document is designed to ensure that my research questions for the study are properly addressed with corresponding interview questions.

In the table, please review each research question and the corresponding interview questions. For each interview question, consider how well the interview question addresses the research question. If the interview question is directly relevant to the research question, please highlight “Keep as stated.” If the interview question is irrelevant to the research question, please highlight “Delete it.” Finally, if the interview question can be modified to best fit with the research question, please suggest your modifications in the space provided. You may also recommend additional interview questions you deem necessary.

Once you have completed your analysis, please return the completed form to me via email to [REDACTED].

Thank you for your willingness to serve as a peer reviewer for my data collection instrument. If you have any questions, please contact me at [REDACTED] or [REDACTED] or my Committee Chair, Dr. Lani Fraizer at [REDACTED].

Sincerely,

Lyndsay Phillips
Doctoral Student in Organizational Leadership
Pepperdine University, Graduate School of Education and Psychology

APPENDIX G

Peer Reviewer Evaluation Form

Research Questions	Corresponding Interview Questions
<p>RQ1: What strategies and practices are employed by therapeutic community service providers in their respective organizations?</p>	<p>IQ 1: What business strategies and/or practices have helped you be successful in your organization?</p> <p>Keep as stated Delete question Suggested modification:</p>
	<p>IQ 2: What leadership practices and/or techniques have helped you be successful as a therapeutic community service provider?</p> <p>Keep as stated Delete question Suggested modification:</p>
	<p>IQ 3: What education/training or work experiences prepared you in your role as a therapeutic community service provider?</p> <p>Keep as stated Delete question Suggested modification:</p>
	<p>IQ4: What personal characteristics prepared you in your role as a therapeutic community service provider?</p> <p>Keep as stated Delete question Suggested modification:</p>

RQ 2: What challenges are faced by therapeutic community service providers in their respective organizations?	<p>IQ 5: What challenges have you faced in leading therapeutic community services within and outside your organization?</p> <p>Keep as stated Delete question Suggested modification:</p> <hr/> <p>IQ 6: How did you overcome these challenges?</p> <p>Keep as stated Delete question Suggested modification:</p>
RQ3: How do therapeutic community service providers measure success in rehabilitative activities to help former substance abusers maintain sobriety?	<p>IQ 7: How do you define and measure success pertaining to rehabilitative activities to help former substance abusers maintain sobriety?</p> <p>Keep as stated Delete question Suggested modification:</p> <hr/> <p>IQ 8: How do you define and measure your success as a therapeutic community service provider?</p> <p>Keep as stated Delete question Suggested modification:</p> <hr/>
RQ4: What recommendations do therapeutic community service providers	IQ 9: What advice or recommendations would you give to therapeutic community service providers?

<p>provide for aspiring leaders of therapeutic communities?</p>	<p>Keep as stated Delete question Suggested modification:</p> <hr/> <p>IQ 10: What advice or recommendations would you give to therapeutic community organizations?</p> <p>Keep as stated Delete question Suggested modification:</p> <hr/> <p>IQ 11: Is there anything else you would like to add?</p> <p>Keep as stated Delete question Suggested modification:</p>
-----------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

APPENDIX H

IRB Approval Notices



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: December 17, 2018

Protocol Investigator Name: Lyndsay Phillips

Protocol #: 18-04-799

Project Title: Brazilian Addiction Recovery: An Exploration of Best Practices

School: Graduate School of Education and Psychology

Dear Lyndsay Phillips:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 14, 2019

Protocol Investigator Name: Lyndsay Phillips

Protocol #: 18-04-799

Project Title: Brazilian Addiction Recovery: An Exploration of Best Practices

School: Graduate School of Education and Psychology

Dear Phillips:

Thank you for submitting your amended exempt application to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the **Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual** at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

APPENDIX I

CITI Program Certification



Completion Date 24-Mar-2017
Expiration Date 23-Mar-2022
Record ID [REDACTED]

This is to certify that:

Lyndsay Phillips

Has completed the following CITI Program course:

GSEP Education Division

(Curriculum Group)

GSEP Education Division - Social-Behavioral-Educational (SBE)

(Course Learner Group)

1 - Basic Course

(Stage)

Under requirements set by:

Pepperdine University

CITI

Verify at [REDACTED]

APPENDIX J

Turn-it-in Originality Report

ORIGINALITY REPORT

5%

SIMILARITY INDEX

4%

INTERNET SOURCES

3%

PUBLICATIONS

2%

STUDENT PAPERS
